BlueCross BlueShield of Texas

Your Health Care Benefits Program

Blue Essentials℠ Plan

For Employees of G&A Outsourcing, Inc., dba G&A Partners

Account #213560

Group #261315

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BLUE CROSS AND BLUE SHIELD OF TEXAS
a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association
(herein called "BCBSTX" or "HMO")

1001 East Lookout Drive
Richardson, Texas 75082
1-877-299-2377
www.bcbstx.com

CERTIFICATE OF COVERAGE

NOTICE TO CONSUMER

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

This Certificate of Coverage ("Certificate") is a component of the Group Agreement ("Group Agreement") between the Group and Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation ("HMO"). The Group Agreement governs the terms and conditions of coverage. Provisions of this Certificate include the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any amendments, or attachments, which may be delivered with the Certificate or added later.

The HMO agrees to provide You coverage for health care benefits in keeping with the conditions, rights, and privileges set forth under this Certificate. Your coverage under this Certificate is subject to the terms, conditions, and provisions of the Group Agreement.

This Certificate explains Your covered health care benefits. Coverage for services or supplies is provided only if furnished while You are a Member and this coverage is in force. Except as shown under the **GENERAL PROVISIONS**: **COBRA Continuation Coverage** and **State Continuation Coverage section,** coverage is not provided for any services received before coverage starts or after coverage ends.

The defined terms in this Certificate are capitalized and shown under the appropriate provision of the Certificate or under the DEFINITIONS section of the Certificate; and, if applicable, in the amendments or attachments to this Certificate. Whenever these terms are used, the meaning is consistent with the definition given.

The Group Agreement concerning this Certificate is not a Workers' Compensation insurance policy. Consult with Your employer to determine if they maintain a Workers' Compensation policy. This Certificate is governed by applicable federal law and the laws of Texas. Any reference to "applicable law" will include applicable laws and rules, including, but not limited to, statutes, ordinances, and administrative decisions and regulations.

This Certificate may be delivered to You electronically, however, a paper copy is available upon request. Please read this entire Certificate carefully, and take the time getting to know your benefit program, including its benefit limits, exclusions, Your rights and obligations and those of the HMO. Learning how this plan works can help make the best use of your health care benefits. It is the Group's and Your responsibility to understand the terms and conditions under this Certificate, because in some circumstances, certain medical services are not covered or may require Prior Authorization by the HMO.

No services are covered by this Certificate if current Premiums have not been paid. If the Group Agreement is terminated for nonpayment of Premiums, You are responsible for the cost of services received during the thirty (30) – one hundred eighty (180) day Grace Period.

This Certificate applies only to Your HMO coverage. It does not limit Your ability to receive health care services that are not Covered Services. No Participating Provider or other Provider, institution, facility or agency is an agent or employee of the HMO.

THIS "CERTIFICATE" IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, please review the Guide to Health Insurance for people with Medicare available from BCBSTX.

Have a complaint or need help?

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

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

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

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

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

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

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

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

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

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

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

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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AMENDMENTS

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

Blue Essentials℠ Network
Blue Essentials℠ Plan

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

IMPORTANT NOTE: Copayments and, if applicable, Coinsurance shown below indicate the amount You are required to pay, expressed as either a fixed dollar amount or a percentage of the Allowable Amount. Copayments and any applicable Coinsurance or Deductibles will be applied for each Covered Service rendered by a Participating Provider or Emergency Care received from a non-Participating Provider unless otherwise indicated. You will not be responsible for any Copayments/Coinsurance once the Deductible(s) and out-of-pocket maximum(s) listed below have been met. Copayments/Coinsurance, Deductibles and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law. Some services may require Prior Authorization by the HMO.

Out-of-Pocket Maximums Per Calendar Year including Pharmacy Benefits	
Per Individual Member	$8,150
Per Family	$16,300
Deductible Per Calendar Year	
Per Individual Member	$7,500
Per Family	$15,000
Professional Services	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	$30 Copay
Participating Specialist Physician ("Specialist") Office or Home Visit	$60 Copay
Inpatient Hospital Services	
Inpatient Hospital Services	No Coinsurance after Deductible
Outpatient Facility Services	
Outpatient Surgery	No Coinsurance after Deductible
Outpatient Hospital Based Infusion Therapy	No Coinsurance after Deductible
Radiation Therapy	No Coinsurance after Deductible
Dialysis	No Coinsurance after Deductible

Outpatient Laboratory and X-Ray Services	
Arteriograms, Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG), Myelogram, Positron Emission Tomography (PET Scan), per procedure	No Coinsurance after Deductible
Other X-Ray Services	No Coinsurance after Deductible
Outpatient Lab	No Coinsurance after Deductible
Rehabilitation Services	
Rehabilitation Services and Therapies Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any rehabilitation services visit maximums.	$30 Copay for PCP or $60 Copay for Specialist, No Coinsurance after Deductible for Inpatient Hospital Services or No Coinsurance after Deductible for Outpatient Facility Services, as applicable.
Maternity Care and Family Planning Services	
Maternity Care	
Prenatal and Postnatal Visit – Copay is applied to the first office visit only. Subsequent office visits are covered in full.	$30 Copay for PCP or $60 Copay for Specialist
Inpatient Hospital Services	No Coinsurance after Deductible
Family Planning Services: • Diagnostic counseling, consultations and planning services • Insertion or removal of intrauterine device (IUD), including cost of device • Diaphragm or cervical cap fitting, including cost of device • Insertion or removal of birth control device implanted under the skin, including cost of device • Injectable contraceptive drugs, including cost of drug	$30 Copay for PCP or $60 Copay for Specialist; unless otherwise covered under Contraceptive Services described in **Health Maintenance and Preventive Services.**
• Vasectomy	$30 Copay for PCP or $60 Copay for Specialist or No Coinsurance after Deductible for Outpatient Surgery, as applicable.
Infertility Services Diagnostic counseling, consultations, planning and treatment services	$30 Copay for PCP or $60 Copay for Specialist
Artificial insemination, for each procedure and all services related to procedure (cost of sperm not covered)	$30 Copay for PCP or $60 Copay for Specialist or No Coinsurance after Deductible for Outpatient Surgery, as applicable.
Pregnancy Terminations Limited to pregnancies which, as certified by a Physician, place the woman in danger of death unless an abortion is performed.	$30 Copay for PCP or $60 Copay for Specialist, No Coinsurance after Deductible for Inpatient Hospital Services or No Coinsurance after Deductible for Outpatient Surgery, as applicable.

SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS

Behavioral Health Services	
Outpatient Mental Health Care	$30 Copay for in-office or home visit or benefits paid same as any other illness for other services, as applicable.
Inpatient Mental Health Care	No Coinsurance after Deductible
Serious Mental Illness	$30 Copay for in-office or home visit or benefits paid same as any other illness for other services, as applicable.
Chemical Dependency Services	$30 Copay for in-office or home visit or benefits paid same as any other illness for other services, as applicable.
Emergency Services	
Emergency Care Facility	$300 Copay, waived if admitted. (If admitted, any charges described in **Inpatient Hospital Services** will apply.)
Emergency Care - Physician	No Coinsurance after Deductible
Urgent Care Services	
Urgent Care	$75 Copay Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply.
Retail Health Clinics	
Retail Health Clinics	PCP amount listed in **Professional Services**.
Ambulance Services	
Ambulance Services	No Coinsurance after Deductible
Extended Care Services	
Skilled Nursing Facility Services, for each day, up to 60 days per Calendar Year	No Coinsurance after Deductible
Hospice Care, for each day	No Coinsurance after Deductible
Home Health Care, per visit	No Coinsurance after Deductible
Health Maintenance and Preventive Services	
Well child care through age 17	No Copay
Periodic health assessments for Members age 18 and older	No Copay

Immunizations	
• Childhood immunizations required by law for Members through age 6	No Copay
• Immunizations for Members over age 6	No Copay
Exam for prostate cancer, once every twelve months	No Copay
Bone mass measurement for osteoporosis	No Copay
Well-woman exam, once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)	No Copay
Screening mammogram for female Members age 35 and over and for female Members with other risk factors, once every twelve months	No Copay
• Outpatient facility or imaging centers	No Copay
Contraceptive Services and Supplies	
• Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices	No Copay
Breastfeeding Support, Counseling and Supplies	
• Electric breast pumps limited to one (1) per Calendar Year.	No Copay
Hearing Loss	
• Screening test from birth through 30 days and for infants, children, and adolescents as otherwise required by HRSA guidelines	No Copay
• Follow-up care from birth through 24 months	No Copay
Rectal screening for the detection of colorectal cancer for Members age 45 and older:	
• Annual fecal occult blood test, once every twelve months	No Copay
• Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years	No Copay
• Colonoscopy, limited to 1 every 10 years	No Copay
Preventive eye screenings for infants, children, and adolescents as required by HRSA guidelines	No Copay
Diagnostic eye and ear screenings for Members through age 17, once every twelve months	$30 Copay for PCP or $60 Copay for Specialist
Diagnostic eye and ear screening for Members age 18 and older, once every two years	$30 Copay for PCP or $60 Copay for Specialist
Early detection test for cardiovascular disease, limited to 1 every 5 years	
• Computer tomography (CT) scanning	No Coinsurance after Deductible
• Ultrasonography	No Coinsurance after Deductible

Early detection test for ovarian cancer (CA125 blood test), once every twelve months	$30 Copay for PCP or $60 Copay for Specialist
Dental Surgical Procedures	
Dental Surgical Procedures (limited Covered Services)	$30 Copay for PCP or $60 Copay for Specialist, No Coinsurance after Deductible for Inpatient Hospital Services or No Coinsurance after Deductible for Outpatient Surgery, as applicable.
Cosmetic, Reconstructive or Plastic Surgery	
Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	$30 Copay for PCP or $60 Copay for Specialist, No Coinsurance after Deductible for Inpatient Hospital Services or No Coinsurance after Deductible for Outpatient Surgery, as applicable.
Allergy Care	
Testing and Evaluation	No Coinsurance after Deductible
Injections	No Coinsurance after Deductible
Serum	No Coinsurance after Deductible
Diabetes Care	
Diabetes Self-Management Training, for each visit	$30 Copay for PCP or $60 Copay for Specialist
Diabetes Equipment	No Coinsurance after Deductible
Diabetes Supplies Some Diabetes Supplies are only available utilizing pharmacy benefits, through a Participating Pharmacy. You must pay the applicable **PHARMACY BENEFITS** amount shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences.	No Coinsurance after Deductible
Prosthetic Appliances and Orthotic Devices	
Prosthetic Appliances and Orthotic Devices $300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer.	No Coinsurance after Deductible
Cochlear Implants Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	No Coinsurance after Deductible Any additional charges as described in **Outpatient Surgery** may also apply.
Durable Medical Equipment	
Durable Medical Equipment	No Coinsurance after Deductible

Hearing Aids	
Hearing Aids Maximum benefit – one per ear, every 36 months	No Coinsurance after Deductible
Speech and Hearing Services	
Speech and Hearing Services Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech and hearing services visit maximums.	Benefits paid same as any other physical illness
Telehealth, Teledentistry, and Telemedicine Services	
Telehealth, Teledentistry, and Telemedicine Services	PCP amount listed in **Professional Services**

Pharmacy Benefits		
Participating Pharmacy Retail Pharmacy One Copayment amount per 30-day supply, up to a 30-day supply only. Extended Prescription Drug Supply Program (if allowed by the Prescription Order) – One Copayment amount per 30-day supply, up to a 90-day supply.	Tier 1	$5 Copay
	Tier 2	$15 Copay
	Tier 3	$45 Copay
	Tier 4	$85 Copay
	Out-of-Area Drug	$85 Copay
Mail-Order Program Extended Prescription Drug Supply Program (if allowed by the Prescription Order) – One Copayment amount per 30-day supply, up to a 90-day supply only	Tier 1	$5 Copay
	Tier 2	$15 Copay
	Tier 3	$45 Copay
	Tier 4	$85 Copay
Specialty Pharmacy Program One Copayment amount per 30-day supply, up to a 30-day supply only.	Tier 5	$150 Copay
Select Vaccinations obtained through the Pharmacy Vaccine Network	$0 Copay	

Diabetes Supplies are covered as described in **PHARMACY BENEFITS**. All provisions listed in **PHARMACY BENEFITS** will apply, including Copayments/Coinsurance, Deductibles, and any pricing differences.

The Copayment for insulin included in the Drug List will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of Insulin needed to fill the prescription.

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

DEFINITIONS

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

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

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

Approved Clinical Trial means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition. The trial must be:

- Conducted under an investigational new drug application reviewed by the United States Food and Drug Administration;
- Exempt from obtaining an investigational new drug application;
- Approved or funded by:
    - The National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, or a cooperative group or center of any of the foregoing entities;
    - A cooperative group or center of the United States Department of Defense or the United States Department of Veterans Affairs;
    - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support groups; or
    - The United States Departments of Veterans Affairs, Defense, or Energy if the study or investigation has been reviewed and approved through a system of peer review determined by the United States Secretary of Health and Human Services to:
        - Be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        - Provide unbiased scientific review by individuals who have no interest in the outcome of the review; or
        - Conducted and approved by an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

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

Calendar Year means the period beginning January 1 of any year and ending December 31 of the same year.

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 that provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved by the HMO or its designated behavioral health administrator. The facility must be:

- Affiliated with a Hospital under a contractual agreement with an established system for patient Referral;
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations;
- Licensed, certified or approved as a Chemical Dependency treatment program or center by an agency of the state of Texas having legal authority to so license, certify or approve; or
- If outside Texas, licensed, certified or approved as a Chemical Dependency treatment program or center by the appropriate agency of the state in which it is located having the legal authority to so license, certify or approve.

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

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

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

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

Contract Month means the period of each succeeding month beginning on the Group Agreement effective date.

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

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

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

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

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

DEFINITIONS

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

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

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

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

Domestic Partner means a person with whom You have entered into a domestic partnership in accordance with the Group's guidelines and who has been determined eligible for coverage by the HMO. Note: Domestic Partner coverage is available at Your employer's discretion. Contact Your employer for information on whether Domestic Partner coverage is available for Your Group and if COBRA-like benefits are available. For specific criteria or forms needed to establish eligibility for coverage under this Certificate, contact Your Group's Human Resources Department.

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

Effective Date of Coverage means the commencement date of coverage under this Certificate as shown in the records of the HMO.

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

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

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

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

- Have been demonstrated in peer-reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;

- Are appropriate for the Hospital or Participating Provider; and
- The Health Care Professional has had the appropriate training and experience to provide the treatment or procedure.

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

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

Grace Period means a period of thirty (30) - one hundred eighty (180) days after all but the first Premium due date, during which period Premiums may be paid to the HMO without lapse of coverage occurring. If payment is not received within thirty (30) - one hundred eighty (180), coverage will be terminated after the 30th – 180th day and You will be liable for the cost of services received during the Grace Period.

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

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

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

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

HMO (Health Maintenance Organization) means Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation.

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

Hospital means an acute care institution that:

- Is duly licensed by the state in which it is located and must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or certified under Medicare;
- Is primarily engaged in providing, on an inpatient basis, medical care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities;
- Provides all services on its premises under the supervision of a staff of Physicians;
- Provides 24-hour a day nursing and Physician service; and
- Has in effect a Hospital utilization review plan.

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

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

Infusion Therapy involves 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.

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

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

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

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction;
- Provided in accordance with and consistent with generally accepted standards of medical practice in the United States;
- Not primarily for Your convenience, or the convenience of Your Participating Provider;
- The most economical supplies or levels of service appropriate for Your safe and effective treatment; and
- If more than one health intervention meets the requirements listed above, Medically Necessary means the most cost effective in terms of type, frequency, extent, site, duration, which is safe and effective for the patient's illness, injury, or disease.

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

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

Member means a Subscriber or Dependent(s) covered under the HMO. This Certificate may refer to a Member as You or Your.

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 HMO or its designated behavioral health administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;

2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Participating Provider when the Covered Service is:

   - Individual, group, family, or conjoint psychotherapy,
   - Counseling,
   - Psychoanalysis,
   - Psychological testing and assessment,
   - The administration or monitoring of psychotropic drugs, or
   - Hospital visits (if applicable) or consultations in a facility listed in **item 5**, below;

3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in **items 1-4**, above, performed in or by a Hospital (if applicable), or other licensed facility or unit providing such care.

Mental Health Treatment Facility means a facility that:

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

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

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

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

Participating describes a Provider that has entered into a contractual agreement with the HMO for the provision of Covered Services to Members.

Payee means individual who resides in this state, or a corporation, trust, partnership, association, or other private legal entity authorized to do business in this state that receives money as payment under an agreement.

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

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

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

DEFINITIONS

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

Premium means the amount the Group or You are required to pay to the HMO to continue coverage.

Primary Care Physician/Practitioner or PCP means the Participating Physician, Physician Assistant or Advanced Practice Nurse who is primarily responsible for providing, arranging and coordinating all aspects of Your health care. You and Your Dependents must each select a PCP from those listed by the HMO to provide primary care services. You may choose a PCP who is a family practitioner, internist, pediatrician and/or Obstetrician/Gynecologist. The PA or APN must work under the supervision of a Participating family practitioner, internist, pediatrician and/or Obstetrician/Gynecologist in the same HMO network.

Prior Authorization means a determination by the HMO that health care services proposed to be provided to a patient are Medically Necessary and appropriate. Prior Authorization processes will be conducted in accordance with Texas Insurance Code, chapter 843, or in accordance with the laws in the state of Texas.

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

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

Provider means any duly licensed institution, Physician, Health Care Professional or other entity which is licensed to provide health care services.

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

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

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

Referral means specific directions or instructions from Your PCP, in conformance with the HMO's policies and procedures that direct You to a Participating Provider for Covered Services.

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

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

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

Retail Health Clinic means a Participating Provider that has entered into a contractual agreement with the HMO to provide treatment of uncomplicated minor illnesses. Retail Health Clinics are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

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

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

Routine patient care costs do not include:

- 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;
- 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;
- The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- A cost associated with managing a clinical trial; or
- The cost of a health care service that is specifically excluded from coverage under the HMO.

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

- Schizophrenia;
- Paranoia and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Obsessive-compulsive disorders; and
- Depression in childhood or adolescence.

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

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

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

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

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

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

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

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

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

You and **Your** means any Member, including Subscriber and Dependents.

WHO GETS BENEFITS

Eligibility

No eligibility rules or variations in Premium will be imposed based on Your health status, medical condition, claims experience, receipt of care, medical history, genetic information, evidence of insurability, disability, or other health status related factor. Coverage under this Certificate is provided regardless of Your race, color, national origin, disability age, sex, gender identity, sexual orientation, political affiliation or expression. Coverage under this Plan does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving benefits under this plan. Variations in the administration, processes or benefits under this Certificate are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentive; disincentives and/or other programs do not constitute discrimination.

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

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

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

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

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

   Additionally, a Dependent shall include a child for whom a Subscriber or a Subscriber's spouse or Domestic Partner is a court-appointed legal guardian, provided proof of such guardianship is submitted with the prospective Dependent's enrollment application/change form; or
5. Be a child of any age, as defined in **item 4** above, who is and continues to be incapable of sustaining employment by reason of mental retardation or physical handicap and is chiefly dependent upon Subscriber for economic support and maintenance. A Subscriber must provide the HMO with a Dependent Child's Statement of Disability form, including, a medical certification of disability, within thirty-one (31) days of the date of such medical certification and subsequently as may be required by the HMO, but not more often than once per year. The HMO's determination of eligibility shall be conclusive; or
6. Have a court order for coverage to be provided for a spouse or minor child under a Subscriber's Health Benefit Plan and a request for enrollment shall be made within thirty-one (31) days after issuance of the court order.

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

Loss of Eligibility. You must notify the HMO of any changes that will affect Your eligibility, or that of Your Dependents, for services or benefits under this Certificate within thirty-one (31) days of the change.

Enrollment and Effective Date of Coverage

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

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

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

Other Enrollment Events. Coverage under this Certificate for persons becoming eligible at times other than the initial enrollment period or the Group Open Enrollment Period will become effective as stated in **items 1-6** below, only if the HMO receives a completed enrollment application/change form and applicable Premium payments Timely. "Timely" means within thirty-one (31) days from the date of the event, unless otherwise specified and agreed upon by the Group and the HMO.

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

2. **Newly Eligible Dependents.** A Subscriber may enroll any person who becomes newly eligible as a Dependent by completing and submitting to the HMO an enrollment application/change form within thirty-one (31) days after attaining eligibility. No proof of insurability shall be required. The Effective Date of Coverage will be the date of the event, i.e., marriage, entry into a domestic partnership, birth, adoption, becoming a party in a lawsuit for adoption or guardianship, unless otherwise specified and agreed upon by the Group and the HMO. Newly eligible Dependents not added to coverage within thirty-one (31) days after the event will become effective in accordance with the provisions for late enrollees.

3. **Newborn Children Coverage**. Coverage will be automatic for a Subscriber or a Subscriber's spouse's or Domestic Partner's newborn child for the first thirty-one (31) days following the date of birth. Coverage will continue beyond the thirty-one (31) days only if the child is an eligible Dependent and You notify the HMO (verbally or in writing), or submit a Timely enrollment application/change form to the HMO and make, or agree to make, any additional Premium payments in accordance with this Certificate. The Effective Date of Coverage for newborn children shall be the newborn's date of birth.

4. **Newly Adopted Children**. Coverage will be automatic for a newly adopted child of a Subscriber for the first thirty-one (31) days from the date a Subscriber is a party in a lawsuit for adoption or thirty-one (31) days from the date the adoption is final. Coverage will continue beyond the thirty-one (31) days only if the child is an eligible Dependent and You submit an enrollment application/change form to the HMO within thirty-one (31) days after the date a Subscriber becomes a party in a lawsuit for adoption, the date the adoption becomes final, and You make or agree to make any required Premium payments in accordance with this Certificate. The Effective Date of Coverage for newly adopted children shall be the date You become a party in a lawsuit for adoption or the date the adoption is final.

5. **Court-Ordered Dependents.** Dependent children for whom a Subscriber has received a court order requiring a Subscriber to provide health coverage will be covered for an initial period of thirty-one (31) days from the date the Group receives notification of the court order. Coverage will continue beyond the thirty-one (31) days only if You submit to the HMO an appropriate enrollment application/change form within thirty-one (31) days of the date of receipt of the court order by the Group and make, or agree to make, any additional Premium payments in accordance with this Certificate. The Effective Date of Coverage for court-ordered Dependents will be the date the court order is received by the Group.

   Coverage for a Dependent spouse for whom a Subscriber has received a court order requiring You to provide health coverage will be effective on the first day of the month after the HMO receives the appropriate enrollment application/change form and applicable Premium payments, if the HMO receives such form and payments within thirty-one (31) days after issuance of the court order.

6. **Late Enrollees; Special Enrollment Events**. Eligible Subscribers or Dependents initially, or newly eligible for enrollment who do not enroll within thirty-one (31) days after eligibility, are late enrollees and may only be enrolled during a subsequent Group Open Enrollment Period. An eligible Subscriber or Dependent is not a late enrollee in the following situations:

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

   (1) **Marriage or Domestic Partnership**. A Subscriber may enroll a Subscriber and a Subscriber's spouse or Domestic Partner within thirty-one (31) days after the date of marriage or entry into a domestic partnership. The Effective Date of Coverage is the first day of the month following the date of the event unless otherwise specified and agreed upon by the Group and the HMO.

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

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

   (a) **Court-ordered child(ren)**: A Subscriber may enroll himself, if not already covered, and such child(ren) subject to the court order. The Effective Date of Coverage is as of the date the Group receives notice of the court order if the HMO receives an enrollment application/change form within thirty-one (31) days after the date the Group receives a court order or notice of a court order, and You make, or agree to make, any additional Premium payments, unless otherwise specified and agreed upon by the Group and the HMO.

   (b) **Court-ordered spouse**: The Effective Date of Coverage is the first day of the month after the HMO receives an enrollment application/change form, if the HMO receives application/change form within thirty-one (31) days after issuance of the court order and You make, or agree to make, any additional Premium payments, unless otherwise specified and agreed upon by the Group and the HMO.

   b. Loss of Other Coverage. Any individual eligible as a Subscriber or Dependent who did not enroll when initially eligible may enroll if each of the following is true, and if the HMO receives completed enrollment application/change forms and applicable Premium payments within thirty-one (31) days after the date coverage ends or after a claim is denied due to reaching the lifetime limit under another Health Benefit Plan, self-funded employer Health Benefit Plan, or other health insurance coverage (collectively referred to in this subsection as "Prior Health Benefit Plan"):

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

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

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

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

The Effective Date of Coverage under this subsection is the day after prior coverage terminated.

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

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

Provider Information

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

Only services that are performed, prescribed, directed; or authorized in advance by the PCP or HMO are covered benefits under this Certificate except for Emergency Care, Participating Urgent Care, and Retail Health Clinics or Covered Services provided to female Members, who may directly access an Obstetrician/Gynecologist in the same Limited Provider Network as their PCP for: 1) well woman exams; 2) obstetrical care; 3) care for all active gynecological conditions; and 4) diagnosis, treatment, and Referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist. PCPs in a Limited Provider Network will be identified in the HMO Provider directory, or You can call customer service at the toll-free telephone number on the back of Your identification card.

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

Utilization Management

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

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

Prior Authorization

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

Some Covered Services may also require Prior Authorization, which requires the Provider to get approval from the HMO before You are admitted to the Hospital or for certain types of Covered Services. Prior Authorization processes will be conducted in accordance with Texas Insurance Code, Chapter 843, or in accordance with the laws of the state of Texas. Renewal of an existing Prior Authorization issued by the HMO may be requested by a Physician or health care Provider up to 60 days prior to the expiration of the existing Prior Authorization.

On receipt of a request from a Participating Physician or Provider for Prior Authorization, HMO shall review and issue a determination:

- not later than the third calendar day after the date the request is received by HMO for non-hospitalization care;
- within 24 hours of receipt of the request for inpatient and concurrent hospitalization care; or
- within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but not to exceed one hour from receipt of the request if the proposed services involve post-stabilization treatment or a Life-Threatening Disease or Condition.

Some Texas-licensed Providers may qualify for an exemption from Prior Authorization requirements for a particular health care service if the Provider met criteria set forth by applicable law for the particular health care service. If so, where an exemption applies for a particular service, Prior Authorization is not required and will not be denied based on Medical Necessity or medical appropriateness of care. Other Providers providing Your care may not be exempt from such requirements. Exemptions do not apply for services that are materially misrepresented or where the Provider failed to substantially perform the particular service.

For additional information and a current list of medical and health care services that require Prior Authorization, please visit the website at www.bcbstx.com/find-care/where-you-go-matters/utilization-management.com.

Length of Stay/Service Review

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

An extension of a previously approved length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the **COMPLAINT AND APPEAL PROCEDURES** section.

An extension of length of stay/service review, also known as a concurrent Medical Necessity review, is when You, Your Provider, or other authorized representative may submit a request to the HMO for continued services. If You, Your Provider or authorized representative requests to extend care beyond the approved time limit, the HMO will make a determination on the request within the timeframes described in the **Review of Claim Determinations** provision of this Certificate.

Recommended Clinical Review Option

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

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

Recommended Clinical Review is a determination of the Medical Necessity of a proposed service, but it is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this benefit booklet. Please coordinate with Your Provider to submit a written request for Recommended Clinical Review.

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

Contacting Behavioral Health

You, Your Physician, Provider of services, or your authorized representative may contact BCBSTX for a Prior Authorization or Recommended Clinical Review by calling the toll-free telephone number shown on the back of Your Identification Card and following the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same behavioral health line is answered by clinicians available for Inpatient acute reviews only. Requests for residential or Partial Hospitalization are reviewed during regular business hours.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

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

2. **Request for Additional Information**

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

Post-Service Medical Necessity Review

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

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of payment. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of HMO. Post-Service Medical Necessity Review does not guarantee payment of benefits by HMO. However, an HMO may not deny or reduce payment to the physician or provider for services once preauthorized.

2. Request for Additional Information

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

Coverage Determinations

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

Selecting a PCP

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

In addition to a PCP, female Members may also select an Obstetrician/Gynecologist (OB/GYN) in Your PCP's network of Participating Providers for gynecological and obstetric conditions, including annual well-woman exam and maternity care, without first obtaining a Referral from a PCP or calling HMO.

Your PCP may be part of a Limited Provider Network, so Your choice of a PCP may affect the network of Participating Providers available to You. For instance, if Your PCP is part of a Limited Provider Network, You may only be referred to Participating Providers who are associated with the same Limited Provider Network. (A Limited Provider Network is made up of Physicians in separate offices who form an association to provide health care services to HMO Members.) You can be referred to Participating Providers who are not associated with that group or Limited Provider Network only for Covered Services that are not available within the group or Limited Provider Network. You may be required to choose an Obstetrician or Gynecologist who belongs to the same Limited Provider Network as Your PCP but a female Member's right to directly access an Obstetrician or Gynecologist will not be infringed upon. PCPs in a Limited Provider Network will be identified in the HMO Provider directory, or You can call customer service at the toll-free telephone number on the back of Your identification card.

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

Your PCP

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

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

Changing Your PCP

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

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

Continuity of Care

If You are under the care of a Participating Provider who stops participating in HMO's network, (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or for fraud), HMO will continue coverage for that Provider's Covered Services if all the following conditions are met:

- You are:
  - undergoing a course of treatment for a serious and complex condition;
  - undergoing institutional or inpatient care;
  - scheduled to undergo nonelective surgery from the Provider (including receipt of post-operative care from such Provider with respect to such surgery;
  - pregnant or undergoing a course of treatment for the pregnancy; or
  - determined to be terminally ill.

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

- the Provider submits a request to HMO to continue coverage of Your care that identifies the condition for which You are being treated and, when required, indicates that the Provider reasonably believes that discontinuing treatment could cause You harm; and
- the Provider agrees to continue accepting the same reimbursement that applied when participating in HMO's network, and not to seek payment from You for any amounts for which You would not be responsible if the Provider were still participating in HMO's network.

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

You have the right to appeal any decision made for a request for benefits under this subsection as explained in the **COMPLAINT AND APPEAL PROCEDURES** section of this Certificate.

Specialist as PCP

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

Availability of Providers

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

Out-of-Network Services

You may obtain Covered Services from Providers who are not part of HMO's network of Participating Providers when receiving Emergency Care. Also, court-ordered Dependents living outside the Service Area may use non-Participating Providers.

If Covered Services are not available from Participating Providers within the access requirements established by law and regulation, HMO will allow a Referral by Your PCP to a non-Participating Provider, if approved by HMO. If Your PCP is in a Limited Provider Network, in determining whether a Covered Service is available through Participating Providers, HMO will first consider Participating Providers in the PCP's Limited Provider Network. If the Covered Service is not available in the Limited Provider Network, then HMO's entire network will be considered.

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

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

In some instances, You will be unable to choose a Participating Provider, such as when You receive services from a non-Participating facility-based Provider in a network facility, or when You receive services from a non-Participating laboratory or diagnostic imaging facility in connection with care provided by Your Participating Provider. In these instances, Your services may be covered and You would not responsible for any amounts beyond the Copayment/Coinsurance and any Deductibles. If You receive a bill from an out-of-network Provider in such circumstances, please contact HMO.

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

Inpatient Care by Non-PCP

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

Provider Communication

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

Your Responsibilities

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

Refusal to Accept Treatment

You may, for personal reasons, refuse to accept procedures or treatment by a Participating Provider. Participating Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Provider-patient relationship and as obstructing the provision of proper medical care. Participating Providers shall use their best efforts to render all necessary and appropriate Professional Services in a manner compatible with Your wishes, insofar as this can be done consistent with the Participating Provider's judgment as to the requirements of proper medical practice. If You refuse to follow a recommended treatment or procedure, and the Participating Provider informed You of his belief that no professionally acceptable alternative exists, neither HMO nor any Participating Provider shall have any further responsibility to provide care for the condition under treatment.

Premium Payment

On or before the Premium due date, Group or its designated agent shall remit to HMO on behalf of each Subscriber and Dependents the amount specified in the Group Agreement.

Failure to Render Payments

Only if HMO receives Your stipulated payment, shall You be entitled to health services covered hereunder and then only for the Contract Month for which such payment is received. If any required payment is not received by the Premium due date of the Contract Month, then You will be terminated at the end of the Grace Period of the Contract Month. You will be responsible for the cost of services rendered to You during the Grace Period of the Contract Month in the event that Premium payments are not made by Group.

Change in Premium Rates

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

Federal Balance Billing and Other Protections

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

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

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

- Emergency care from facilities or Providers who do not participate in Your network; and
- Care furnished by non-Participating Providers during Your visit to a participating facility; and
- Air ambulance services from non-Participating Providers if the services would be covered with a Participating Provider.

Non-Participating Providers may not bill You for more than Your deductible, coinsurance or copayment for these types of services. There are limited instances when a non-Participating Provider of the care listed above may send You a bill for up to the amount of that Provider's billed charges. You are only responsible for payment of the non-Participating Provider's billed charges if, in advance of receiving services, You signed a written notice form that complies with applicable state and/or federal law.

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

2. Primary Care Physician/Practitioner Selection

The Plan generally requires the designation of a Primary Care Physician/Practitioner (PCP). You have the right to designate any PCP who participates in our network and who is available to accept You or Your family Members.

Until You make this designation, BCBSTX designates one for You. For information on how to select a PCP and for a list of the participating PCPs, contact BCBSTX at www.bcbstx.com or customer service at the toll-free telephone number on the back of Your Identification Card.

For Dependent children, You may designate any Participating Provider who specializes in pediatric care as their Primary Care Physician/Practitioner (PCP).

3. Obstetrics or Gynecological Care

You are not required to obtain a referral or authorization from Your Primary Care Physician/Practitioner (PCP) before obtaining Covered Services from any Participating Provider specializing in obstetrics or gynecology. However, before obtaining Covered obstetrical or gynecological care, the Provider must comply with certain policies and procedures required by Your Plan, including Prior Authorization and referral

policies. For a list of Participating Providers who specialize in obstetrics or gynecology, visit www.bcbstx.com or contact customer service at the toll-free telephone number on the back of Your Identification Card.

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

Member Complaint Procedure

Any problem or claim between You and HMO or between You and a Participating Provider must be dealt with using the process described in **COMPLAINT AND APPEAL PROCEDURES**. Complaints may concern non-medical or medical aspects of care as well as this Certificate, including its breach or termination.

Identification Card

Cards issued by HMO to Members under this Certificate are for identification only. The identification card confers no right to services or other benefits under this Certificate. To be entitled to any services or benefits, the holder of the identification card must be a Member on whose behalf all applicable Premiums under this Certificate have actually been paid.

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

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

Always remember to carry Your identification card with You and present it to Your Providers or 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 and/or each covered Dependent (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, HMO will provide a new identification card.

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

1. The unauthorized, fraudulent, improper, or abusive use of identification cards issued to You and Your covered Dependents will include, but not be limited to, the following actions, when intentional:

   a. use of the identification card prior to Your Effective Date of Coverage;
   b. use of the identification card after Your date of termination of coverage under the Certificate;
   c. obtaining prescription drugs or other benefits for persons not covered under the Certificate;
   d. obtaining prescription drugs or other benefits that are not covered under the Certificate;
   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 Certificate;
   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 Certificate;
   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 Member can result in, but is not limited to, the following sanctions being applied to all Members covered under Your coverage:

   a. denial of benefits;
   b. cancellation of coverage under the Certificate for all Members 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 Members receiving benefits under Your coverage;
e. notice to proper authorities of potential violations of law or professional ethics.

Member Claims Refund

You are not expected to make payments, other than required Copayments/Coinsurance and any Deductibles, for any benefits provided hereunder. However, if You make such payments, You may send HMO a claim for reimbursement, and when a refund is in order, the Provider shall make such refund to You. Your claim will be allowed only if You notify HMO within ninety (90) days from the date on which covered expenses were first incurred, unless it can be shown that it was not reasonably possible to give notice within the time limit, and that notice was given as soon as reasonably possible. However, benefits will not be allowed if notice of claim is made beyond one (1) year from the date covered expenses were incurred, except for Prescription Drug claims which must be filed within ninety (90) days of the date of purchase to qualify for reimbursement under Pharmacy Benefits. You must provide written proof of such payment to HMO within one (1) year of occurrence.

Within fifteen (15) days of receipt of written notice of a claim, HMO shall acknowledge receipt of claim and begin any necessary investigation. It may be necessary for HMO to request additional information from You. Claims shall be acted upon within fifteen (15) business days of receipt of a completed claim unless You are notified that additional time is needed and why. HMO will act on a completed claim no later than forty-five (45) days after the additional time notification is given to You. If HMO notifies You that HMO will pay a claim or part of a claim, HMO will pay an approved claim not later than five (5) business days after the date notice is made. Visit the website at www.bcbstx.com or call customer service at the toll-free number on the back of Your identification card to obtain a medical claim form or a prescription reimbursement claim form.

Claim or Benefit Reconsideration

If a claim or a request for benefits is partly or completely denied by HMO, You will receive a written explanation of the reason for the denial and be entitled to a full review. If You wish to request a review or have questions regarding the explanation of benefits, call or write customer service at the phone number or address on the back of Your identification card. If You are not satisfied with the information received either on the call or in written correspondence, You may request an appeal of the decision or file a Complaint. You may obtain a review of the denial by following the process set out in **COMPLAINT AND APPEAL PROCEDURES**.

Service Area

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

Provider Information

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

Only services that are performed, prescribed, directed or ordered in advance by a qualified Participating Provider or HMO are covered benefits under this Certificate except for Emergency Care, Participating Urgent Care, and Retail Health Clinics.

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

Utilization Management

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

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

Prior Authorization

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

Some Covered Services may also require Prior Authorization, which requires the Provider to get approval from the HMO before You are admitted to the Hospital or for certain types of Covered Services. Prior Authorization processes will be conducted in accordance with Texas Insurance Code, Chapter 843, or in accordance with the laws of the state of Texas. Renewal of an existing Prior Authorization issued by the HMO may be requested by a Physician or health care Provider up to 60 days prior to the expiration of the existing Prior Authorization.

On receipt of a request from a Participating Physician or Provider for Prior Authorization, HMO shall review and issue a determination:

- not later than the third calendar day after the date the request is received by HMO for non-hospitalization care;
- within 24 hours of receipt of the request for inpatient and concurrent hospitalization care; or
- within the time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but not to exceed one hour from receipt of the request if the proposed services involve post-stabilization treatment or a Life-Threatening Disease or Condition.

Some Texas-licensed Providers may qualify for an exemption from Prior Authorization requirements for a particular health care service if the Provider met criteria set forth by applicable law for the particular health care service. If so, Prior Authorization is not required for a particular service where an exemption applies and will not be denied based on Medical Necessity or medical appropriateness of care. Other Providers providing Your care may not be exempt from such requirements. Exemptions do not apply for services that are materially misrepresented or where the Provider failed to substantially perform the particular service.

For additional information and a current list of medical and health care services that require Prior Authorization, please visit the website at www.bcbstx.com.

Length of Stay/Service Review

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

An extension of a previously approved length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the **COMPLAINT AND APPEAL PROCEDURES** section.

An extension of length of stay/service review, also known as a concurrent Medical Necessity review, is when You, Your Provider, or other authorized representative may submit a request to the HMO for continued services. If You, Your Provider or authorized representative requests to extend care beyond the approved time limit, the HMO will make a determination on the request within the timeframes described in the **Review of Claim Determinations** provision of this Certificate.

Recommended Clinical Review Option

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

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

Recommended Clinical Review is a determination of the Medical Necessity of a proposed service, but it is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this benefit booklet. Please coordinate with Your Provider to submit a written request for Recommended Clinical Review.

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

Contacting Behavioral Health

You, Your Physician, Provider of services, or your authorized representative may contact BCBSTX for a Prior Authorization or Recommended Clinical Review by calling the toll-free telephone number shown on the back of Your Identification Card and following the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Outpatient requests should be requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same behavioral health line is answered by clinicians available for Inpatient acute reviews only. Requests for residential or Partial Hospitalization are reviewed during regular business hours.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

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

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from Your Provider or pharmacist. In addition to the written request for Recommended Clinical Review, the Provider or pharmacist

may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan, and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSTX to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

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

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of payment. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of HMO. Post-Service Medical Necessity Review does not guarantee payment of benefits by HMO. However, an HMO may not deny or reduce payment to the physician or provider for services once preauthorized.

2. Request for Additional Information

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

Coverage Determinations

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

A Primary Care Physician/Practitioner (PCP)

A PCP is primarily responsible for providing medical care, as appropriate, either by providing treatment or by issuing Referrals to direct You to Participating Providers. Your plan does allow You to self-refer to any Participating Provider for Medically Necessary care.

Continuity of Care

If You are under the care of a Participating Provider who stops participating in HMO's network, (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or for fraud), HMO will continue coverage for that Provider's Covered Services if all the following conditions are met:

- You are:
  - undergoing a course of treatment for a serious and complex condition;
  - undergoing institutional or inpatient care;

- scheduled to undergo nonelective surgery from the Provider (including receipt of post-operative care from such Provider with respect to such surgery;
- pregnant or undergoing a course of treatment for the pregnancy; or
- determined to be terminally ill.

A serious and complex condition is one that:

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

- the Provider submits a request to HMO to continue coverage of Your care that identifies the condition for which You are being treated and, when required, indicates that the Provider reasonably believes that discontinuing treatment could cause You harm; and
- the Provider agrees to continue accepting the same reimbursement that applied when participating in HMO's network, and not to seek payment from You for any amounts for which You would not be responsible if the Provider were still participating in HMO's network.

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

You have the right to appeal any decision made for a request for benefits under this subsection as explained in the **COMPLAINT AND APPEAL PROCEDURES** section of this Certificate.

Specialist as PCP

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

Availability of Providers

HMO cannot guarantee the availability or continued participation of a particular Provider. Either HMO or any Participating Provider may terminate the Provider contract or limit the number of Members that will be accepted as patients. If the PCP initially selected cannot accept additional patients, You will be given an opportunity to make another PCP selection. You are encouraged then to cooperate with HMO to select another PCP. Your plan does allow You to self-refer to any qualified Participating Provider for Medically Necessary care.

Out-of-Network Services

You may obtain Covered Services from Providers who are not part of HMO's network of Participating Providers when receiving Emergency Care. Also, court-ordered Dependents living outside the Service Area may use non-Participating Providers.

If Covered Services are not available from Participating Providers within the access requirements established by law and regulation, HMO will allow a Referral to a non-Participating Provider, but the following apply:

- The request must be from a Participating Provider.

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

In some instances, You will be unable to choose a Participating Provider, such as when You receive services from a non-Participating facility-based Provider in a network facility, or when You receive services from a non-Participating laboratory or diagnostic imaging facility in connection with care provided by Your Participating Provider. In these instances, Your services may be covered and You would not responsible for any amounts beyond the Copayment/Coinsurance and any Deductibles. If You receive a bill from an out-of-network Provider in such circumstances, please contact HMO.

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

Provider Communication

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

Your Responsibilities

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

Refusal to Accept Treatment

You may, for personal reasons, refuse to accept procedures or treatment by a Participating Provider. Participating Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Provider-patient relationship and as obstructing the provision of proper medical care. Participating Providers shall use their best efforts to render all necessary and appropriate Professional Services in a manner compatible with Your wishes, insofar as this can be done consistent with the Participating Provider's judgment as to the requirements of proper medical practice. If You refuse to follow a recommended treatment or procedure, and the Participating Provider informed You of his belief that no professionally acceptable alternative exists, neither HMO nor any Participating Provider shall have any further responsibility to provide care for the condition under treatment.

Premium Payment

On or before the Premium due date, Group or its designated agent shall remit to HMO on behalf of each Subscriber and Dependents the amount specified in the Group Agreement.

Failure to Render Payments

Only if HMO receives Your stipulated payment, shall You be entitled to health services covered hereunder and then only for the Contract Month for which such payment is received. If any required payment is not received by the Premium due date of the Contract Month, then You will be terminated at the end of the Grace Period of the Contract Month. You will be responsible for the cost of services rendered to You during the Grace Period of the Contract Month in the event that Premium payments are not made by Group.

Change in Premium Rates

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

Federal Balance Billing and Other Protections

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

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

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

- Emergency care from facilities or Providers who do not participate in Your network; and
- Care furnished by non-Participating Providers during Your visit to a participating facility; and
- Air ambulance services from non-Participating Providers if the services would be covered with a Participating Provider.

Non-Participating Providers may not bill You for more than Your deductible, coinsurance or copayment for these types of services. There are limited instances when a non-Participating Provider of the care listed above may send You a bill for up to the amount of that Provider's billed charges. You are only responsible for payment of the non-Participating Provider's billed charges if, in advance of receiving services, You signed a written notice form that complies with applicable state and/or federal law.

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

2. Primary Care Physician/Practitioner Selection

The Plan generally requires the designation of a Primary Care Physician/Practitioner (PCP). You have the right to designate any PCP who participates in our network and who is available to accept You or Your family Members.

Until You make this designation, BCBSTX designates one for You. For information on how to select a PCP and for a list of the participating PCPs, contact BCBSTX at www.bcbstx.com or customer service at the toll-free telephone number on the back of Your Identification Card.

For Dependent children, You may designate any Participating Provider who specializes in pediatric care as their Primary Care Physician/Practitioner (PCP).

3. Obstetrics or Gynecological Care

You are not required to obtain a referral or authorization from Your Primary Care Physician/Practitioner (PCP) before obtaining Covered Services from any Participating Provider specializing in obstetrics or gynecology. However, before obtaining Covered obstetrical or gynecological care, the Provider must comply with certain policies and procedures required by Your Plan, including Prior Authorization and referral policies. For a list of Participating Providers who specialize in obstetrics or gynecology, visit www.bcbstx.com or contact customer service at the toll-free telephone number on the back of Your Identification Card.

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

Member Complaint Procedure

Any problem or claim between You and HMO or between You and a Participating Provider must be dealt with using the process described in **COMPLAINT AND APPEAL PROCEDURES**. Complaints may concern non-medical or medical aspects of care as well as this Certificate, including its breach or termination.

Identification Card

Cards issued by HMO to Members under this Certificate are for identification only. The identification card confers no right to services or other benefits under this Certificate. To be entitled to any services or benefits, the holder of the identification card must be a Member on whose behalf all applicable Premiums under this Certificate have actually been paid.

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

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

Always remember to carry Your identification card with You and present it to Your Providers or 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 and/or each covered Dependent (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, HMO will provide a new identification card.

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

1. The unauthorized, fraudulent, improper, or abusive use of identification cards issued to You and Your covered Dependents will include, but not be limited to, the following actions, when intentional:
    a. use of the identification card prior to Your Effective Date of Coverage;
    b. use of the identification card after Your date of termination of coverage under the Certificate;
    c. obtaining prescription drugs or other benefits for persons not covered under the Certificate;
    d. obtaining prescription drugs or other benefits that are not covered under the Certificate;
    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 Certificate;
    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 Certificate;
    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 Member can result in, but is not limited to, the following sanctions being applied to all Members covered under Your coverage:
    a. denial of benefits;
    b. cancellation of coverage under the Certificate for all Members 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 Members receiving benefits under Your coverage;
    e. notice to proper authorities of potential violations of law or professional ethics.

Member Claims Refund

You are not expected to make payments, other than required Copayments/Coinsurance and any Deductibles, for any benefits provided hereunder. However, if You make such payments, You may send HMO a claim for reimbursement, and when a refund is in order, the Provider shall make such refund to You. Your claim will be allowed only if You notify HMO within ninety (90) days from the date on which covered expenses were first incurred, unless it can be shown that it was not reasonably possible to give notice within the time limit, and that notice was given as soon as reasonably possible. However, benefits will not be allowed if notice of claim is made beyond one (1) year from the date covered expenses were incurred, except for Prescription Drug claims which must be filed within ninety (90) days of the date of purchase to qualify for reimbursement under Pharmacy Benefits. You must provide written proof of such payment to HMO within one (1) year of occurrence.

Within fifteen (15) days of receipt of written notice of a claim, HMO shall acknowledge receipt of claim and begin any necessary investigation. It may be necessary for HMO to request additional information from You. Claims shall be acted upon within fifteen (15) business days of receipt of a completed claim unless You are notified that additional time is needed and why. HMO will act on a completed claim no later than forty-five (45) days after the additional time notification is given to You. If HMO notifies You that HMO will pay a claim or part of a claim, HMO will pay an approved claim not later than five (5) business days after the date notice is made. Visit the website at www.bcbstx.com or call customer service at the toll-free number on the back of Your identification card to obtain a medical claim form or a prescription reimbursement claim form.

Claim or Benefit Reconsideration

If a claim or a request for benefits is partly or completely denied by HMO, You will receive a written explanation of the reason for the denial and be entitled to a full review. If You wish to request a review or have questions regarding the explanation of benefits, call or write customer service at the phone number or address on the back of Your identification card. If You are not satisfied with the information received either on the call or in written correspondence, You may request an appeal of the decision or file a Complaint. You may obtain a review of the denial by following the process set out in **COMPLAINT AND APPEAL PROCEDURES**.

Service Area

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

SERVICE AREA

Service Area

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

MAP0511

SERVICE AREA

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

COMPLAINT AND APPEAL PROCEDURES

Customer Inquiries

You or a designated representative may direct inquiries to an HMO customer service representative by mail or by calling the toll free telephone number on the back of Your ID card. Inquiries resolved to Your satisfaction will be tracked by the HMO. If an inquiry is not resolved promptly to Your satisfaction, it will be handled according to the Complaint procedure described below.

How to File a Complaint with the HMO

A "Complainant" means You or another person, including a Physician or Provider, designated to act on Your behalf, who files a Complaint.

A "Complaint" means any dissatisfaction expressed by a Complainant orally or in writing to HMO about any aspect of HMO's operation, including, but not limited to:

- information relied upon in making the benefit determination;
- HMO administration;
- procedures related to review or appeal of an Adverse Determination;
- the denial, reduction or termination of a service for reasons not related to medical necessity, including an Out-of-Network denial because services rendered do not meet the definition of Emergency Care as shown in the **DEFINITIONS** section;
- the way a service is provided; or
- disenrollment decisions.

It does not mean a misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to Your satisfaction. A Complaint also does not include a Provider's or Member's oral or written expression of dissatisfaction or disagreement with an Adverse Determination, which is defined under **How to Appeal an Adverse Determination.**

Within five (5) business days of receiving a Complaint, the HMO will send Complainant a letter acknowledging the date of receipt, along with a description of the HMO's Complaint process and timeframes. If the Complaint was oral, HMO will also enclose a one-page Complaint form clearly stating that the form must be filled out and returned to HMO for prompt resolution of the Complaint.

Within thirty (30) calendar days after HMO receives the written Complaint or Complaint form, HMO will investigate and resolve the Complaint and send Complainant a letter explaining HMO's resolution. The letter will include: 1) the specific medical and contractual reasons for the decision, including any applicable benefit exclusion, limitation or medical circumstance; 2) additional information required to adjudicate a claim, if needed; 3) the specialization of any Provider consulted; and 4) a full description of the Complaint appeal process, including deadlines for the appeal process and for the final decision on the appeal.

If You dispute the resolution of the Complaint, You may follow the HMO's Complaint appeals process described under **How to Appeal an HMO Complaint Decision**. If Your health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502(a) of ERISA.

Complaints concerning emergencies or denial of continued hospital stays will be investigated and resolved in accordance with the medical or dental immediacy of the case, but no later than one business day from HMO's receipt of the Complaint.

HMO will not engage in any retaliatory action against You or the Group, including termination or refusal to renew this Certificate of Coverage, because You or the Group has reasonably filed a Complaint against the HMO or appealed a decision of HMO. HMO also shall not retaliate against a Physician or Provider, including termination or refusal to renew their contract, because the Physician or Provider has, on behalf of a Member, reasonably filed a Complaint against the HMO or appealed a decision of HMO.

How to Appeal an HMO Complaint Decision

If the Complaint is not resolved to Your satisfaction, the HMO Complaint appeal process gives You the right to appear in person, by telephone or other technological methods before a Complaint appeal panel in the Service Area where

You normally receive health care services, unless Complainant agrees to another site. The Complaint appeal panel can also consider a written appeal.

HMO will send Complainant an acknowledgment letter no later than five (5) business days after the date HMO receives the written request for appeal, and will complete the appeals process no later than thirty (30) calendar days after receiving the written request for appeal.

To advise HMO on resolution of the dispute, HMO will appoint persons to a Complaint appeal panel composed of an equal number of HMO staff, Physicians or other Providers, and Members of the HMO. Complaint appeal panel representatives will not have been previously involved in the disputed decision. Physicians or other Providers must have experience in the area of care that is in dispute and must be independent of any Physician or Provider who made any prior determination. If specialty care is in dispute, the Complaint appeal panel must include a person who is a Specialist in that field. Members of the HMO on the Complaint appeal panel will not be employees of the HMO.

No later than the fifth business day before the scheduled meeting of the Complaint appeal panel, unless Complainant agrees otherwise, HMO will provide to Complainant or Complainant's designated representative:

- documentation to be presented to the Complaint appeal panel by HMO staff;
- the specialization of any Physicians or Providers consulted during the investigation;
- the name and affiliation of each HMO representative on the Complaint appeal panel; and
- the date and location of the hearing.

Complainant or a designated representative, if Member is a minor or disabled, is entitled to appear before the Complaint appeal panel in person or by conference call or other appropriate technology, and to:

- present written or oral information;
- present alternative expert testimony;
- request the presence of and question those responsible for making the prior determination that resulted in the appeal; and
- bring any person Complainant wishes, but only Complainant may directly question meeting participants.

Complainant or designee will receive a written decision of the Complaint appeal, including the specific medical determination, clinical basis and contractual criteria used to reach the final decision, and the toll- free telephone number and address of the Texas Department of Insurance (TDI). Additionally, in the case of a denied Complaint appeal due to services not meeting the definition of Emergency Care as shown in the Definitions section, the written decision will also include notice of Your right to have an Independent Review Organization (IRO) review the denial and the procedures to obtain a review as shown below in How to Appeal to an Independent Review Organization (IRO).

Complaint appeals relating to an ongoing emergency or denial of continued hospitalization shall be investigated and resolved in accordance with the medical or dental immediacy of the case, but no later than one business day from HMO's receipt of the Complainant's request for an appeal. At the request of Complainant, HMO shall provide (instead of a Complaint appeal panel) a review by a Physician or Provider who has not previously reviewed the case and is of the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under consideration in the appeal. The Physician or Provider reviewing the appeal may interview the patient or patient's designated representative and will decide the appeal. The Physician or Provider may deliver initial notice of the appeal decision orally if he then provides written notice no later than the third day after the date of the decision.

Upon request and free of charge, Complainant or 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 HMO;
- medical judgments, including whether a particular service is Experimental, Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by HMO in connection with the denied claim, whether or not the advice was relied upon to make the decision.

How to Appeal to the Texas Department of Insurance

Anyone, including persons who attempted to resolve Complaints through HMO's Complaint process and are dissatisfied with the resolution, may report an alleged violation to TDI, Consumer Protection (111-1A), P. O. Box 149091, Austin, Texas 78714-9091.

You may file a TDI Complaint:

- by mailing to the address listed above; or
- online at www.tdi.texas.gov.

For general information or information about how to resolve insurance-related Complaints call TDI Consumer Help line between 8 a.m. and 5 p.m., Central Time, Monday through Friday at (800) 252-3439. To request a TDI Complaint form call (800) 599-SHOP, or in Austin call (800)252-3439.

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

- additional information is needed;
- an on-site review is necessary;
- HMO, the Physician or Provider, or Complainant does not provide all documentation necessary to complete the investigation; or
- other circumstances beyond TDI's control occur.

How to Appeal an Adverse Determination

An "Adverse Determination" means a determination by HMO or a utilization review agent that the health care services provided or proposed to be provided to You are not Medically Necessary or are Experimental/Investigational. Adverse Determination does not mean a denial of health care services due to the failure to request prospective or concurrent utilization review. In life-threatening or urgent care circumstances, if HMO has discontinued coverage of prescription drugs or intravenous infusions for which You were receiving health benefits under the Certificate, or if You do not receive a timely decision, You are entitled to an immediate appeal to an Independent Review Organization ("IRO") and are not required to comply with HMO's appeal of an Adverse Determination process. An IRO is an organization independent of the HMO which may perform a final administrative review of an Adverse Determination made by HMO.

The HMO maintains an internal appeal system that provides reasonable procedures for notification, review, and resolution of an oral or written appeal concerning dissatisfaction or disagreement with an Adverse Determination. You, a person acting on Your behalf, or Your Provider of record must initiate an appeal of an Adverse Determination (which is not part of the Complaint process).

When You, a person acting on Your behalf, or Your Provider of record expresses orally or in writing any dissatisfaction or disagreement with an Adverse Determination, HMO or a utilization review agent will treat that expression as an appeal of an Adverse Determination.

Within five (5) business days after HMO receives an appeal of Adverse Determination, HMO will send to the appealing party a letter acknowledging the date HMO received the appeal and a list of documents the appealing party must submit. If the appeal was oral, HMO will enclose a one-page appeal form clearly stating that the form must be returned to HMO for prompt resolution. HMO has thirty (30) calendar days from receipt of a written appeal of Adverse Determination or the appeal form to complete the appeal process and provide written notice of the appeal decision to the appealing party. The appeal will be reviewed by a health care Provider not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review.

Notice of HMO's final decision on the appeal will include the dental, medical and contractual reasons for the resolution; clinical basis for the decision and the specialization of Provider consulted. A denial will also include notice of Your right to have an IRO review the denial and the procedures to obtain a review.

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

Expedited Appeal of Adverse Determination (Emergencies or Continued Hospitalization Situations)

Appeals relating to ongoing emergencies, denials of continued hospital stays, or the discontinuance by HMO of prescription drugs or intravenous infusions for which You were receiving health benefits under the Certificate are referred directly to an expedited appeal process for investigation and resolution. They will be concluded in accordance with the medical or dental immediacy of the case but in no event will exceed one (1) working day from the date all information necessary to complete the appeal is received. Initial notice of the decision may be delivered orally if followed by written notice of the decision within three (3) days.

The appeal will be reviewed by a health care Provider not involved in the initial decision, who is in the same or similar specialty that typically manages the medical or dental condition, procedure or treatment under review. The Physician or Provider reviewing the appeal may interview the patient or patient's designated representative.

How to Appeal to an Independent Review Organization (IRO)

This procedure (not part of the Complaint process) pertains only to appeals of Adverse Determinations and Complaint appeals concerning denials because services do not meet the definition of Emergency Care as shown in the **DEFINITIONS** section. In life-threatening or urgent care circumstances, if HMO has discontinued coverage of prescription drugs or intravenous infusions for which You were receiving health benefits under the Certificate, or if You do not receive a timely decision, You are entitled to an immediate appeal to an IRO and are not required to comply with HMO's appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by HMO may seek review of the decision by an IRO assigned to the appeal. At the time the appeal is denied, HMO will provide You, Your designated representative or Your Provider of record, information on how to appeal the denial, including the approved form, which You, Your designated representative, or Your Provider of record must complete and return to HMO to begin the independent review process. A request for review by an IRO must be submitted within four (4) months after Your receipt of the Adverse Determination.

- In life-threatening, urgent care situations, or if HMO has discontinued coverage of prescription drugs or intravenous infusions for which You were receiving health benefits under the Certificate, You, Your designated representative, or Your Provider of record may contact HMO by telephone to request the review and provide the required information.
- HMO will submit medical records, names of Providers and any documentation pertinent to the decision of the IRO.
- HMO will comply with the decision by the IRO.
- HMO will pay for the independent review.

Upon request and free of charge, Member or 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 HMO;
- medical judgements, including whether a particular service is Experimental, Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by HMO 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 health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502(a) of ERISA.

COVERED SERVICES AND BENEFITS

This section lists the covered services under the Plan.

Please note that services must be determined to be Medically Necessary by the Plan in order to be covered.

Coverage of items and services provided to You is subject to Blue Cross and Blue Shield of Texas' (BCBSTX) policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, utilization management, and clinical payment and coding policies, which are updated throughout the Plan year. These policies are resources utilized by BCBSTX when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug, or device is Medically Necessary and is eligible as a covered service, or is Experimental/Investigational, cosmetic, or a convenience item.

The clinical payment and coding policies are intended to ensure accurate documentation for services performed and require all Providers to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to:

- Uniform Billing ("UB") Editor;
- American Medical Association ("AMA");
- Current Procedural Terminology ("CPT®");
- CPT® Assistant;
- Healthcare Common Procedure Coding System ("HCPCS");
- ICD-10 CM and PCS;
- National Drug Codes ("NDC");
- Diagnosis Related Group ("DRG") guidelines;
- Centers for Medicare and Medicaid Services ("CMS"):
- National Correct Coding Initiative ("NCCI") Policy Manual;
- CCI table edits; and
- Other CMS guidelines.

Coverage for covered services is subject to the code edit protocols for services/procedures billed and claim submissions are subject to applicable claim review which may include, but is not limited to, review of any terms of benefit coverage, Provider contract language, medical and medical management policies, utilization or clinical review, utilization management policies, clinical payment and coding policies, as well as coding software logic, including, but not limited to, lab management or other coding logic or edits.

Any line on the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included in the Allowable Amount and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the Provider rendering the item or service or submitting the claim is a Participating or non-Participating Provider. The most up-to-date medical policies and clinical procedure and coding policies are available at www.bcbstx.com, or by contacting a Customer Service Representative at the toll-free telephone number shown on your Identification Card.

Copayments/Coinsurance

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

Deductibles

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

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

Out-of-Pocket Maximums

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

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

Requirements

All Covered Services, unless otherwise specifically described:

- Must be Medically Necessary;
- Must be performed, prescribed, directed, or authorized in advance by the PCP and/or the HMO;
- Must be rendered by a Participating Provider;
- Are subject to the Copayments/Coinsurance and any other amount shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate;
- May have limitations, restrictions or exclusions described under the **LIMITATIONS AND EXCLUSIONS** section of this Certificate**;** and
- May require Prior Authorization.

Professional Services

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

PCP or Specialist Office Visits. Services provided in the medical office of the PCP or authorized Specialist for the diagnosis and treatment of illness or injury.

PCP or Specialist Home Visits. Medically Necessary home visits provided by a Participating Physician when, in the judgment of the PCP or authorized Specialist, the nature of the illness or injury so indicates.

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

Inpatient Hospital Services

Services, except Emergency Care and treatment of breast cancer, must be arranged by Your PCP and have obtained Prior Authorization by the HMO. Covered Services include:

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

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

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

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

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

        (1) A recipient who is a Member covered under the HMO;
        (2) A donor who is a Member covered under the HMO; or
        (3) A donor who is not a Member covered under the HMO.

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

(1) Donor search and acceptability testing of potential live donors;
(2) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
(3) 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 Member for the following services and 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 other than payment for Covered Services and supplies identified above; and
(4) Organ or tissue (xenograft) obtained from another species.

Outpatient Facility Services

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

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

Outpatient Laboratory and X-Ray Services

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

Rehabilitation Services

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

Treatment of Acquired Brain Injury will be covered the same as any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy, and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment; neurofeedback therapy, remediation, post-acute transition services, and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury. To ensure that appropriate post-acute care treatment is provided, the HMO includes coverage for periodic reevaluation for a Member who: (1) has incurred an Acquired Brain Injury; (2) has been unresponsive to treatment; and (3) becomes responsive to treatment at a later date. Services may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living facility, or any other facility at which appropriate services or therapies may be provided.

Benefits for Autism Spectrum Disorder will not apply towards, and are not subject to, any rehabilitation services visit maximums indicated under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate.

Maternity Care and Family Planning Services

Maternity Care. The HMO provides coverage for inpatient care for the mother and the newborn in a Hospital for a minimum of forty-eight (48) hours following an uncomplicated vaginal delivery, or ninety-six (96) hours following

an uncomplicated delivery by cesarean section. Prior Authorization is not required. Upon request, the length-of-stay may be extended if HMO determines that an extension is Medically Necessary.

Covered Services, which may require Prior Authorization, include:

1. Prenatal visits;
2. Use of Hospital delivery rooms and related facilities. A separate Hospital admission Copayment/Coinsurance and any Deductibles will be required for a newborn child at the time of delivery. If a newborn child is discharged and readmitted to a Hospital more than five (5) days after the date of birth, a separate Hospital admission Copayment/Coinsurance and any Deductibles for such readmission will be required;
3. Administration of a newborn screening test, including the test kit, required by the state of Texas;
4. Use of newborn nursery and related facilities;
5. Special procedures as may be Medically Necessary and authorized by a PCP or designated Obstetrician/Gynecologist; and
6. Postnatal visits. If the mother or newborn is discharged before the minimum hours of inpatient coverage have passed, the HMO provides coverage for Post-Delivery Care for the mother and newborn. Post-Delivery Care may be provided at the mother's home, or a Participating Provider's office or facility. A newborn child will not be required to receive health care services only from Participating Providers if born outside the Service Area due to an emergency, or born in a non-network facility, to a mother who is not a Member. The HMO may require the newborn to be transferred to a Participating facility, at the HMO's expense, when determined to be medically appropriate by the newborn's treating Physician.

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

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

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

Note: some benefits for family planning are available under the **Health Maintenance and Preventive Services** section of this Certificate.

Infertility Services. Covered Services, which may require Prior Authorization, include:

1. Diagnostic counseling, consultations, planning services and treatment for problems of fertility and Infertility, subject to the exclusions under the **LIMITATIONS AND EXCLUSIONS** section of this Certificate. Once the Infertility workup and testing have been completed, subsequent workups and testing will require approval of the HMO Medical Director; and
2. Artificial insemination for treatment of Infertility (cost of sperm is not covered).

Pregnancy Terminations. Medically Necessary pregnancy terminations (abortions) for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed are covered. Abortions must be provided by a licensed Physician, but the HMO may allow other health Providers to provide Covered Services that may be provided under applicable state law by such Providers, including cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible. Elective, non-therapeutic abortions are not covered. Services may require Prior Authorization by the HMO.

Behavioral Health Services

Benefits and coverage for behavioral health services are provided under the same terms and conditions applicable to this Plan's medical and surgical benefits and coverage. The HMO will not impose quantitative or nonquantitative treatment limitations on benefits for behavioral health services that are generally more restrictive than treatment limitations imposed on coverage of benefits for medical or surgical services.

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

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

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

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

Chemical Dependency Services. Coverage for treatment of Chemical Dependency is the same as coverage for treatment of any other physical illness but is restricted as described under the **LIMITATIONS AND EXCLUSIONS** section of this Certificate. Inpatient treatment for Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Some services may require Prior Authorization by the HMO or its designated behavioral health administrator.

Emergency Services

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

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

You may be entitled to protection from balance billing if You receive Out-of-Area Emergency Care. If You received services because You believed that failing to get care placed Your health or the health of a spouse, child or unborn child in danger, but You have questions about whether Your claim was processed as Emergency Care or questions about a balance bill, please call the toll-free telephone number on the back of Your Member ID card.

If post stabilization care is required in a non-Participating Hospital after an Emergency Care condition that originated in a Hospital emergency facility or in a Participating comparable facility (as defined in this paragraph), has been treated and stabilized, the treating Physician or Provider may contact HMO or its designee, but Prior Authorization is not required for post-stabilization care in a non-Participating Hospital. For the purposes of this paragraph, “comparable facility” includes the following:

1. Any stationary or mobile facility, including, but not limited to, Level V Trauma Facilities, and Rural Health Clinics, that have licensed or certified, or both licensed and certified, personnel and equipment to provide Advanced Cardiac Life Support consistent with American Heart Association and American Trauma Society standards of care, and a free-standing emergency medical care facility as that term is defined under Insurance Code §843.002 (concerning Definitions);

2. For purposes of Emergency Care related to mental illness, a mental health facility that can provide 24- hour residential and psychiatric services and that is:

    a. A facility operated by the Texas Department of State Health Services;
    b. A private mental Hospital licensed by the Texas Department of State Health Services;
    c. A community center as defined by Texas Health and Safety Code §534.001 (concerning Establishment);
    d. A facility operated by a community center or other entity the Texas Department of State Health Services designates to provide mental health services;
    e. An identifiable part of a general Hospital in which diagnosis, treatment, and care for persons with mental illness is provided, and that is licensed by the Texas Department of State Health Services; or
    f. A Hospital operated by a federal agency.

Regardless of other provisions under this Certificate to the contrary, for Emergency Care rendered by Providers who are not part of the HMO's network of Participating Providers (non-Participating Provider) or otherwise contracted with the HMO, the HMO shall fully reimburse such Providers at its usual and customary rate, or an agreed-upon rate, not to exceed billed charges. This amount is calculated excluding any in-network Copayment/Coinsurance and any Deductibles imposed with respect to a Member.

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

Urgent Care Services

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

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

Retail Health Clinics

Retail Health Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional PCP office visit, Urgent Care visit, or Emergency Care visit. A PCP Referral is not required to obtain Covered Services.

Ambulance Services

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

For non-Emergency Care, air ambulance services are only covered when authorized by a PCP or the HMO and 1) Ambulance transportation is Medically Necessary, and 2) terrain, distance, Your physical condition, or other circumstances require the use of air ambulance services rather than ground ambulance services.

Extended Care Services

Covered Services include the following when prescribed by a PCP and authorized by the HMO. Services may have additional limitations as indicated under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate, and the restrictions or exclusions described under the **LIMITATIONS AND EXCLUSIONS** section of this Certificate.

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

Hospice Care. Care that is provided by a Hospital, Skilled Nursing Facility, Hospice, or a duly licensed Hospice Care agency, is approved by the HMO, and is focused on a palliative, rather than curative treatment, for Members who have a medical condition and a prognosis of less than 6 months to live. Coverage includes counseling services routinely provided by the Hospice Care Provider, including bereavement counseling. For care provided in a Hospital, charges described under the **Inpatient Hospital Services** section of this Certificate will apply.

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

Health Maintenance and Preventive Services

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

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

1. Well child care for Members through age twenty-two (22), which includes evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents;

2. Periodic health assessments for Members twenty-two (22), and older, based on age, sex, and medical history;

3. Routine immunizations recommended by the American Academy of Pediatrics, U.S. Public Health Service for people in the United States and required by law; immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved. Examples of covered immunizations include diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, rotavirus, Covid 19, and any other immunization that is required by the law for a child. (Allergy injections are not considered immunizations under this benefit provision.);

4. Bone mass measurement for the detection of low bone mass and to determine risk of osteoporosis and fractures associated with osteoporosis, for qualified individuals including postmenopausal women who are not receiving estrogen replacement therapy; individuals with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or individuals receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy;

5. Preventive care and screenings provided with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the HRSA such as a well-woman gynecological exam (once every twelve months) for female Members, and a medically recognized diagnostic exam for the early detection of cervical cancer for female Members age eighteen (18) and older. Your PCP or any Obstetrician/Gynecologist in Your PCP's network of Participating Providers may perform the well-woman exam. The exam may include, but is not limited to, a conventional Pap smear screening; a screening using liquid-based cytology methods alone or in combination with a test approved by the United States Food and Drug Administration for the detection of human papillomavirus. You must first obtain a Referral from Your PCP for follow-up services related to treatment of a disease or condition that is not within the scope of an Obstetrician/Gynecologist. For help in selecting an Obstetrician/Gynecologist, refer to the HMO Provider directory, contact Your PCP or call customer service;

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

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

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

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

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

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

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

   Breastfeeding Support, Counseling, and Supplies. Covered Services include support and counseling services obtained from a Participating Provider during pregnancy and/or in the post-partum period. Benefits will also be provided for the rental of hospital grade breast pumps (not to exceed the total cost) or purchase of manual or electric breast pump, breast pump supplies, and breast milk storage supplies, with a written prescription from a Provider, and are not subject to Coinsurance, Deductible, Copayment, or benefit maximums when received from a Participating Provider. Benefits for the purchase of an electric breast pump are limited to one per Benefit Period. You may be required to pay the full amount and submit a reimbursement claim form along with the written prescription to the HMO with itemized receipts for the manual, electric or Hospital-grade breast pump and supplies. Visit the website at www.bcbstx.com to obtain a claim form.

   Benefits are limited as indicated under the **SCHEDULE OF COPAYMENTS AND BENEFITS LIMITS** section of this Certificate;

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

9. A medically recognized rectal screening exam for the detection of colorectal cancer for Members age forty-five (45) or older and who are at normal risk for developing colon cancer. Covered Services include:

   a. all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the USPSTF for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and
   b. any initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy, which may be subject to any applicable Copayments, Coinsurance, and Deductible, if the results of the initial colonoscopy, test, or procedure are abnormal.; and

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

Examples of other covered preventive services that are not subject to Copayment/Coinsurance, Deductible or dollar maximums include smoking cessation counseling services and intervention (including FDA-approved tobacco cessation medications), healthy diet counseling and obesity screening/counseling. NOTE: Smoking cessation medications are covered under **PHARMACY BENEFITS** with a Prescription Order from Your Health Care Professional.

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

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

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

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

1. Diagnostic eye and ear screenings (once every twelve months) performed or authorized by a PCP for Members through age seventeen (17) to identify vision and hearing problems. Eye screenings may be performed in PCP's office and do not include refractions;

2. Diagnostic eye and ear screenings (once every two years) performed or authorized by a PCP for Members eighteen (18) and older to identify vision and hearing problems. Eye screenings may be performed in PCP's office and do not include refractions;

3. Early detection test 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 Member 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 Member 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 under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate;

4. Early detection test for ovarian cancer. Benefits are available for a CA 125 blood test and any other test or screenings approved by the United States Food and Drug Administration for the detection of ovarian cancer. Benefits are available once every twelve months for female Members age eighteen (18) and older. Your PCP or any Participating Obstetrician/Gynecologist in Your PCP's network of Participating Providers may administer the test.

Dental Surgical Procedures

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

1. Treatment for accidental injury, injury resulting from domestic violence, or a medical condition, to Sound Natural Adult Teeth, the jaw bones, or surrounding tissues, not caused by biting or chewing. "Sound Natural Adult Teeth" means teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures;
2. Treatment or correction of a non-dental physiological condition which has resulted in severe functional impairment;
3. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
4. Diagnostic and surgical treatment of conditions affecting the temporomandibular joint (including the jaw or craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology; and
5. Removal of complete bony impacted teeth.

Cosmetic, Reconstructive or Plastic Surgery

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

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

Allergy Care

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

Diabetes Care

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

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

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

When the following diabetes equipment and supplies are obtained, You may be required to pay the full amount of their bill and submit a reimbursement claim form to the HMO with itemized receipts. Visit the website at www.bcbstx.com to obtain a medical claim form. If You choose to purchase diabetes supplies utilizing pharmacy benefits, You must pay the applicable **PHARMACY BENEFITS** Copayment/Coinsurance and any Deductibles shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate and any applicable pricing differences. No claim forms are required.

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

- Blood glucose monitors
- Insulin pumps and necessary accessories
- Insulin infusion devices
- Podiatric appliances (including up to two pairs of therapeutic footwear per Calendar Year
- Glucose meter solution
- Biohazard disposable containers

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

The diabetes equipment and supplies in the list below are only available utilizing pharmacy benefits. When You purchase these items utilizing pharmacy benefits, You must pay the applicable **PHARMACY BENEFITS** Copayment/Coinsurance and any Deductibles shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate and any applicable pricing differences. No claim forms are required.

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

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

Prosthetic Appliances and Orthotic Devices

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

1. Initial Prosthetic Appliances, including professional fitting services related to the fitting and use of these devices, are covered subject to restrictions under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and **LIMITATIONS AND EXCLUSIONS** sections of this Certificate.
2. Repair and replacement of Prosthetic Appliances and orthotic devices are covered unless the repair or replacement is a result of misuse or loss by You.
3. Orthopedic braces, such as orthopedic appliances used to support, align, or hold bodily parts in a correct position; crutches, including rigid back, leg, or neck braces; casts for treatment of any part of the legs, arms, shoulders, hips, or back; special surgical and back corsets; and Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints that are custom designed for the purpose of assisting the function of a joint.
4. Breast prostheses and surgical brassieres after mastectomy.
5. One wig needed as a result of current chemotherapy or radiation treatment for cancer, subject to any maximum amount indicated under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate.
6. One cochlear implant, which includes an external speech processor and controller, per impaired ear, is covered. Coverage also includes related treatments such as habilitation and rehabilitation services, fitting and dispensing services, and the provision of ear molds as necessary to maintain optimal fit of hearing aids. Implant components may be replaced as Medically Necessary or audiologically necessary.

Durable Medical Equipment

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

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

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

a) Urinary catheters;
b) Wound care or dressing supplies given by a Provider during treatment for covered health services; and
c) Medical-grade compression stockings when considered medically necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient.

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

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

a) Pouches, face plates, and belts;
b) Irrigation sleeves, bags, and ostomy irrigation catheters;
c) Skin barriers; and
d) Deodorants, filters, lubricants, tape, appliance cleaners, adhesive and adhesive remover.

Hearing Aids

Covered Services and equipment, which may require Prior Authorization, include one audiometric examination to determine type and extent of hearing loss once every thirty-six (36) months, and the fitting and purchase of a hearing aid device(s). Coverage also includes fitting and dispensing services, the provision of ear molds as necessary to maintain optimal fit of hearing aids, and habilitation and rehabilitation services. Hearing aids are limited to 1 per ear every thirty-six (36) months. Exclusions are listed under the **LIMITATIONS AND EXCLUSIONS** section of this Certificate.

Speech and Hearing Services

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

Benefits for Autism Spectrum Disorder will not apply towards, and are not subject to, any speech and hearing services visit maximums indicated under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate.

Therapies for Children with Developmental Delays

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

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

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

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

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

Autism Spectrum Disorder

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

Individuals providing treatment prescribed under that plan must be:

1. A Health Care Professional:
    - Who is licensed, certified, or registered by an appropriate agency of the state of Texas;
    - Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
    - Who is certified as a Provider under the TRICARE military health system.
2. An individual acting under the supervision of a Health Care Professional described under item 1.

Treatment 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.

All standard contractual provisions under this Certificate will apply, including, but not limited to, defined terms, limitations, and exclusions.

Benefits for Autism Spectrum Disorder will not apply towards any visit maximum indicated under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of the Certificate. Please review the Rehabilitation Services provision and the Speech and Hearing Services provisions under this section of the Certificate.

Routine Patient Costs for Participants in Certain Clinical Trials

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

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

Telehealth, Teledentistry, and Telemedicine Services

Telehealth Services, Teledentistry Dental Services and Telemedicine Medical Services are covered as defined under the **DEFINITIONS** section of the Certificate and may require Prior Authorization. Services covered under this section may not be excluded from coverage solely on the basis that the service is not provided through an in-person consultation.

Diagnostic Mammograms and Other Breast Imaging

Diagnostic Imaging is covered to the same extent as screening mammograms as described under the **COVERED SERVICES AND BENEFITS** and **Health Maintenance and Preventive Services** sections of this Certificate**.**

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

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

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

The Copayment/Coinsurance amounts indicated under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and **Health Maintenance and Preventive Services** sections of this Certificate for screening mammograms will apply, but without Member age restrictions.

LIMITATIONS AND EXCLUSIONS

The following is a list of services and supplies that are *generally* not covered or limited in coverage. Your plan may contain exceptions to this list based on the plan design purchased. Please refer to the Certificate of Coverage for your specific provisions, limitations, and exclusions, which you will receive after you enroll.

1. Services or supplies of non-Participating Providers or self-referral to a Participating Provider, except:
   a. Emergency Care;
   b. When authorized by the HMO or a PCP; and
   c. Female Members may directly access an Obstetrician/Gynecologist for: (1) well-woman exams; (2) obstetrical care; (3) care for all active gynecological conditions; and (4) diagnosis, treatment, and referral for any disease or condition within the scope of the professional practice of the Obstetrician/Gynecologist.

2. Services or supplies which, in the judgment of a PCP, or the HMO are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction as defined herein.

3. If a service is not covered, the HMO will not cover any services related to it, except for Routine Patient Care Costs for participants in an Approved Clinical Trial. Related services are:

   a. Services in preparation for the non-covered service;
   b. Services in connection with providing the non-covered service;
   c. Hospitalization required to perform the non-covered service; or
   d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

4. Experimental/Investigational services and supplies. Denials based on Experimental/Investigational services and supplies are Adverse Determinations and are subject to the utilization review process, including review by an Independent Review Organization (IRO) as described in the **COMPLAINT AND APPEALS** section of the Certificate of Coverage.

5. Any charges resulting from the failure to keep a scheduled visit with a Participating Provider or for the acquisition of medical records.

6. Special medical reports not directly related to treatment.

7. Examinations, testing, vaccinations or other services required by employers, insurers, schools, camps, courts, licensing authorities, other third parties or for personal travel.

8. Services or supplies provided by a person who is related to a Member by blood or marriage, and self-administered services.

9. Services or supplies for injuries sustained as a result of war, declared or undeclared, or any act of war, or while on active or reserve duty in the armed forces of any country or international authority.

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

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

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

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

14. Any services, supplies, or drugs received by a Member outside the United States, except for Emergency Care.

15. Transportation services, except as described under the **Ambulance Services** section of the Certificate of Coverage, or when approved by the HMO.

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

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

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

19. Services or supplies for long-term or Custodial Care.

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

21. Private duty nursing not related to Extended Care Services, except when determined to be Medically Necessary and ordered or authorized by a PCP.

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

    a. An inpatient nutritional assessment program provided in, and by, a Hospital and approved by the HMO;
    b. As described under the **Diabetes Care** section of the Certificate of Coverage;
    c. As described under the **Autism Spectrum Disorder** section of the Certificate of Coverage; or
    d. As described under the **Therapies for Children with Developmental Delays** section of the Certificate of Coverage.

23. Services or supplies for Cosmetic, Reconstructive or Plastic Surgery, including breast reduction or augmentation (enlargement) surgery, even when Medically Necessary, except as described under the **Cosmetic, Reconstructive, or Plastic Surgery** section of the Certificate of Coverage.

24. Services or supplies provided primarily for:

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

25. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described under the **Maternity Care and Family Planning Services** section of the Certificate of Coverage.

    a. Sterilization reversal (male or female);
    b. Treatment of sexual dysfunction including medications, penile prostheses, and other surgery, and vascular or plethysmographic studies that are used only for diagnosing impotence;
    c. Promotion of fertility through extra-coital reproductive technologies including, but not limited to, super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer, and tubal embryo transfer;
    d. Any services or supplies related to in vitro fertilization or other procedures when You are the donor and the recipient is not a Member;
    e. In vitro fertilization and fertility drugs.

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

27. Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet rich plasma.

28. Treatment of tissue damage or disease in any location with platelet-rich plasma.

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

30. Services or supplies for reduction of obesity or weight, including surgical procedures and prescription drugs, even if the Member has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under the **Preventive Services** section of the Certificate of Coverage.

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

32. Services or supplies for dental care, except as described under the **Dental Surgical Procedures** section of the Certificate of Coverage.

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

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

35. Services or supplies for:

    a. Acupuncture (dry needling, or trigger-point acupuncture;
    b. Intersegmental traction;
    c. All types of home traction devices and equipment;
    d. Vertebral axial decompression sessions;
    e. Surface EMGs;
    f. Spinal manipulation under anesthesia;
    g. Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph, and Dynatron
    h. Balance testing through computerized dynamic posturography sensory organization test.

36. Galvanic stimulators or TENS units.

37. Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

38. Testing of:

    a. Blood for measurement of levels of: Lipoprotein; a small dense low-density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood that might be ordered in people with suspected de-posits in the walls of blood vessels; or

    b. Urine for measurement of collagen cross links, which is a substance that might be ordered in people with suspected high bone turnover; or

    c. Cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).

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

40. Prosthetic Appliances or orthotic devices not described under the **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** sections of the Certificate of Coverage including, but not limited to:

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

41. Supplies for smoking cessation programs and the treatment of nicotine addiction, with the exception of prescription and over-the-counter medications for tobacco cessation and tobacco cessation counseling covered under the **Preventive Services** section referred to above.

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

43. The following psychological/neuropsychological testing and psychotherapy services:
    a. Educational testing;
    b. Employer/government mandated testing;
    c. Testing to determine eligibility for disability benefits;
    d. Testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing);
    e. Testing for vocational purposes (e.g., interest inventories, work related inventories, and career development);
    f. Services directed at enhancing one's personality or lifestyle;
    g. Vocational or religious counseling;
    h. Activities primarily of an educational nature;
    i. Music or dance therapy; or
    j. Bioenergetic therapy.

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

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

46. Residential Treatment Centers for Chemical Dependency that are not:

    a. Affiliated with a Hospital under a contractual agreement with an established system for patient Referral;
    b. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals;
    c. Licensed as a Chemical Dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
    d. 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.

47. Trauma or wilderness programs for behavioral health or Chemical Dependency treatment.

48. Inpatient mental health services that are provided:

    a. By a non-Participating Provider or non-Participating Mental Health Treatment Facility, Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents, although Participating Providers may refer Members to non-Participating Providers for Covered Services not available from Participating Providers as outlined under the **HOW THE PLAN WORKS** section of the Certificate of Coverage; or
    b. For the following diagnosed conditions: Alzheimer's disease, intractable personality disorders, mental retardation, educational testing, or any other testing required by a school system, psychiatric therapy on court order or as a condition of parole or probation, and chronic organic brain syndrome.

49. Replacement for loss, damage or functional defect of hearing aids. Batteries are not covered unless needed at the time of the initial placement of the hearing aid device(s).

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

51. Medical supplies coverage including, but not limited to, compression stockings, ace bandages, wound care or dressing supplies, prescribed or non-prescribed medical and disposable supplies that can be purchased over the counter.

    This exclusion does not apply to:

    a) Ostomy bags and related supplies for which benefits are provided as described under Ostomy Supplies section.
    b) Disposable supplies necessary for the effective use of Durable Medical Equipment for which benefits are provided as described under Durable Medical Equipment section.
    c) Urinary catheters, wound care or dressing supplies given by a provider during treatment for covered services.
    d) Medical grade compression stockings when considered medically necessary. The stockings must be prescribed by a Physician, individually measured and fitted to the patient.
    e) Diabetic supplies for which benefits are provided as described under Diabetes Services section.
    f) Batteries, tubing, nasal cannulas, connectors and masks except when used with Durable Medical Equipment.

    Not all medical supplies are Covered Services, and all are subject to medical review.

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

    a) As provided while confined as an inpatient,
    b) As provided under the **Autism Spectrum Disorder** section of the Certificate of Coverage;
    c) As provided under the **Diabetes Care** section of the Certificate of Coverage;
    d) Contraceptive devices and FDA-approved over-the-counter contraceptives for women with a written prescription from a Participating Provider; or
    e) If covered under the **PHARMACY BENEFITS** section of the Certificate of Coverage.

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

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

55. Some laboratory services are not covered by Your Plan. The following laboratory services are not covered.

    a. Vitamin B12 testing or screening for a Vitamin B12 deficiency in healthy, asymptomatic individual; homocysteine or holotranscobalamin testing to screen for, or confirm a, Vitamin B 12 deficiency; or Vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency.

    b. Vitamin D testing - Routine screening for Vitamin D deficiency with serum testing in asymptomatic individuals and/or during general encounters.

c. Hemoglobin A1c testing in the following situations:

- If You have had a blood transfusion within the past 120 days; or
- If You have a condition associated with increased red blood cell turnover; or
- If You are also being measured for fructosamine.

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

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

f. Diagnosis of Vaginitis Including Multi-target (PCR) Testing.

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

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

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

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

k. Erectile dysfunction - The following tests for the diagnosis of erectile dysfunction are not covered:
   - Angiotensin-converting enzyme insertion/deletion polymorphism testing;
   - Endothelial nitric oxide synthase polymorphism (4 VNTR, G894T, and T786C) testing for estimating risk of erectile dysfunction;
   - Iron binding capacity;
   - Prostatic acid phosphatase.

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

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

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

57. Any procedures, equipment, services, supplies, or charges for abortions except for abortions to terminate a pregnancy which, as certified by a Physician, places You in danger of death or serious risk of substantial impairment of a major bodily function unless an abortion is performed.

Definitions

In addition to the applicable terms provided in the **DEFINITIONS** section of this Certificate, the following terms will apply specifically to this **PHARMACY BENEFITS** section.

Allowable Amount means the maximum amount determined by HMO to be eligible for consideration of payment for a particular Covered Drug. As applied to Participating Pharmacies the Allowable Amount is based on the provisions of the contract between HMO and the Participating Pharmacy in effect on the date of service. As applied to **Prescription Drugs Purchased Outside of the Service Area**, the Allowable Amount is based on the Participating Pharmacy contract rate.

Associated Conditions means the symptoms or side effects associated with Stage-Four Advanced, Metastatic Cancer or its treatment and which, in the judgment of the health care practitioner, further jeopardize the health of a patient if left untreated.

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 brand name due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would also result in a corresponding change in Copayment/Coinsurance obligations from generic to brand name.

Copayment or **Copay** means the dollar amount or the percentage amount paid by the Member for each Prescription Order filled or refilled through a Participating Pharmacy.

Coinsurance means the percentage amount paid by the Member for each Prescription Order filled or refilled through a Participating Pharmacy.

Covered Drug(s) means any Legend Drug:

(1) which is included on the applicable Drug List;
(2) which is Medically Necessary and is ordered by an authorized Health Care Practitioner naming a Member as the recipient;
(3) for which a written or verbal Prescription Order is provided by an authorized Health Care Practitioner;
(4) for which a separate charge is customarily made;
(5) which is not consumed at the time and place that the Prescription Order is written;
(6) for which the U.S. Food and Drug Administration (FDA) has given approval for at least one indication; and
(7) which is dispensed by a Participating Pharmacy and is received by the Member while covered under this Certificate, 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 Your 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.

Drug List means a list of drugs that may be covered under Your Pharmacy Benefits. The Drug List is available by accessing the website at www.bcbstx.com. You may also contact customer service at the toll-free number on Your identification card for more information.

Generic Drug means a drug that has the same active ingredient as the Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs, HMO utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. You should know that not all drugs identified as "generic" by the drug product database, manufacturer, Pharmacy, or Your Physician will adjudicate as generic by HMO. The Drug List, which identifies Generic Drugs, is available by accessing the website at https://www.bcbstx.com; or You may contact customer service at the toll-free number on Your identification card.

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

Non-Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable Drug List as Non-Preferred Brand Name Drug. The Drug List is available by accessing the website at https://www.bcbstx.com.

Non-Preferred Generic Drug means a Generic Drug which appears on the Drug List as Non-Preferred Generic Drug. The Drug List is available by accessing the website at https://www.bcbstx.com.

Non-Preferred Specialty Drug means a Specialty Drug which appears on the Drug List as Non-Preferred Specialty Drug. The Drug List is available by accessing the website at https://www.bcbstx.com.

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order program Pharmacy or a Specialty Pharmacy Provider which have entered into a written agreement with HMO to provide pharmaceutical services to Members under this Certificate.

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

Pharmacy Vaccine Network means the network of certain Participating Pharmacies which have entered into a written agreement with HMO to provide certain vaccinations under this Certificate.

Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable Drug List as Preferred Brand Name Drug. The Drug List is available by accessing the website at https://www.bcbstx.com.

Preferred Generic Drug means a Generic Drug which appears on the Drug List as Preferred Generic Drug. The Drug List is available by accessing the website at https://www.bcbstx.com

Preferred Specialty Drug means a Specialty Drug which appears on the applicable Drug List as Preferred Specialty Drug. The Drug List is available by accessing the website at https://www.bcbstx.com.

Prescription Order means a written or verbal order from Your authorized Health Care Practitioner to a pharmacist for a drug or device to be dispensed.

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

Specialty Pharmacy Provider means a Participating Pharmacy which has entered into a written agreement with HMO to provide Specialty Drugs to Members under this Certificate.

Stage-Four Advanced, Metastatic Cancer means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.

Covered Drugs

Benefits for Medically Necessary Covered Drugs prescribed to treat You for a chronic, disabling, or life-threatening illness covered by the HMO are available if the drug is on the applicable Drug List and has been approved by the United States Food and Drug Administration (FDA) for at least one indication and is recognized by the following for treatment of the indication for which the drug is prescribed:

- A prescription drug reference compendium approved by the Texas Department of Insurance, or
- 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 by the HMO, are eligible for benefits if included on the applicable Drug List. Copayments/Coinsurance and out-of-pocket maximum per Calendar Year for Covered Drugs are shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of this Certificate.

Injectable Drugs. Injectable drugs approved by the FDA for self-administration are covered. Benefits will not be provided under **PHARMACY BENEFITS** for any self-administered drugs dispensed by a Physician.

Diabetes Supplies for Diabetes Care. Insulin, insulin analogs, insulin pens, insulin syringes, needles, injection devices, glucagon emergency kits, lancets, lancet devices, glucose meter solution, test strips specified for use with a corresponding blood glucose monitor, visual reading strips and urine and blood testing strips, and tablets which test for glucose, ketones, and protein, and prescriptive and nonprescriptive oral agents for controlling blood sugar levels are covered.

A separate Copayment/Coinsurance and any Deductibles will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

All supplies, 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 the supplies or equipment.

Emergency Refills of Insulin or Insulin-Related Equipment and Supplies. A pharmacist may exercise professional judgment in refilling a Prescription Order for Insulin or Insulin-Related Equipment or Supplies without the authorization of the prescribing Health Care Practitioner in the following situations:

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

The quantity of an emergency refill of insulin and will not exceed a 30-day supply.

The quantity of an emergency Insulin-Related Equipment and Supplies refill will be the smallest available package and will not exceed a 30-day supply.

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

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

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

You are responsible for the same Copayment/Coinsurance and any Deductibles as for nonemergency refills of diabetes equipment or supplies.

Insulin Drug Program. The total amount you may pay for a Covered Drug that contains insulin and is used to treat diabetes will not exceed the amount shown on your **Schedule of Copayments and Benefit Limits**, up to a 30-day supply, regardless of the amount or type of insulin needed to fill the Prescription Order. The preferred insulin drugs are identified on your Drug List and do not include an insulin drug administered intravenously.

Insulin drugs obtained from a non-Participating Pharmacy or not identified as a preferred insulin drug may be subject to Copayment/Coinsurance and any Deductibles or dollar maximums, if applicable.

Exceptions will not be made for drugs not identified as a preferred insulin drug or for an excluded drug.

Preventive Care. Prescription and over-the-counter drugs which, have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") (to be implemented in the quantities and within the time period allowed under applicable law) or as required by state law will be covered and will not be subject to any Copayment/Coinsurance, Deductible or dollar maximums.

Select Vaccinations obtained through Certain Participating Pharmacies. Benefits for select vaccinations are shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section**.** These vaccinations are available through certain Participating Pharmacies that have contracted with the HMO to provide this service. To locate one of these Participating Pharmacies in the Pharmacy Vaccine Network in Your area and to determine which vaccinations are covered under this benefit, access the website at www.bcbstx.com or contact customer service at the toll-free number on Your Identification Card.

At the time You receive services, present Your Identification Card to the pharmacist. This will identify You as a Member in the HMO health care plan provided by Your employer. The pharmacist will inform You of the appropriate Copayment/Coinsurance and any Deductibles shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

Each Participating Pharmacy in the Pharmacy Vaccine Network that has contracted with the HMO to provide this service may have age, scheduling, or other requirements that will apply, so You are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this Pharmacy benefit. Please refer to the **COVERED SERVICES AND BENEFITS,** and **Health Maintenance and Preventive Services** sections of this Certificate for benefits available for childhood immunizations.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases. Dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases are covered to the same extent as any other Covered Drug available only on the orders of a Health Care Practitioner.

Amino Acid-Based Elemental Formulas. 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.

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. Copayments/Coinsurance and any Deductibles 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.

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

Preferred Insulin Drug Program. The amount you may pay for a preferred insulin drug will not exceed the amount shown on Your SOC, when obtained from a Preferred Participating Pharmacy. The preferred insulin drugs are identified on Your Drug List.

Insulin drugs obtained from a Participating Pharmacy or not identified as a preferred insulin drug may be subject to Copayment / Coinsurance Amount, Deductibles or dollar maximums, if applicable.

Exceptions will not be made for drugs not identified as a preferred insulin drug or for an excluded drug.

Selecting a Pharmacy

When You need a Prescription Order filled, You should use a Participating Pharmacy. Each prescription or refill is subject to the Copayment/Coinsurance shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

Participating Pharmacy. When You go to a Participating Pharmacy, You must pay any Copayment. You may be required to pay for limited or non-Covered Services. No claim forms are required. If You are unsure whether a Pharmacy is a Participating Pharmacy, You may access the website at www.bcbstx.com or contact customer service at the toll-free number on Your Identification Card.

Mail-Order Program. If You elect to use the mail-order service, You must mail Your Prescription Order to the address provided on the mail-order prescription form and send in Your payment for each prescription filled or refilled. Each prescription or refill is subject to the Copayment/Coinsurance and any Deductibles shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section, payable by the Member directly to the mail order Pharmacy.

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

Specialty Pharmacy Program. The Specialty Drug delivery service integrates Specialty Drug benefits with the Member's overall medical and prescription drug benefits. This program provides delivery of medications directly from the Specialty Pharmacy Provider to Your Health Care Practitioner, administration location or to the Member that is undergoing treatment for a complex Medical Condition. Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Provider.

The HMO Specialty Pharmacy Provider delivery service offers:

- Coordination of coverage between You, Your Health Care Practitioner and the HMO,
- 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.

The Drug List which includes these Specialty Drugs is available by accessing the website at www.bcbstx.com or by contacting the customer service at the toll-free number on Your Identification Card. Your cost will be the appropriate Copayment/Coinsurance and any Deductibles shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

Prescription Drugs Purchased Outside of the Service Area. The HMO will reimburse You for the Allowable Amount of the prescription drugs less the Out-of-Area Drug Copayment/Coinsurance shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section**,** for covered prescription drugs which You purchase outside of the Service Area. You must submit a completed claim form to the HMO, within ninety (90) days of the date of purchase to qualify for reimbursement under the **PHARMACY BENEFITS** section**.** You may access the website at www.bcbstx.com/member/forms/formfinder to obtain a prescription drug claim form.

Your Cost

How Copayment Amounts Apply. If the Allowable Amount of the drug is less than the Copayment, You pay the lower cost. When that lower cost is more than the amount You would pay if You purchased the drug without using Your HMO pharmacy benefits or any other source of drug benefits or discounts, You pay such purchase price.

You will pay the applicable Copayment and/or Coinsurance amounts based on the current tier of Brand Name Drug if the prescription has no generic equivalent. If You receive a Brand Name Drug when a generic equivalent is available, the Copayment will be the total of the Generic Drug Copayment and/or Coinsurance plus the difference between the cost of the Generic Drug equivalent and the cost of the Brand Name Drug. Any "differences" between the cost of the Generic Drug equivalent and the cost of the Brand Name Drug will not apply to the deductible or out-of-pocket maximum per Calendar Year and will continue to be applicable after the Out-of-Pocket Maximum is met.

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

You may not be required to pay the difference in cost between the Allowable Amount of the Brand Name Drug and the Allowable Amount of the Generic Drug if there is a medical reason (e.g., adverse event) You need to take the Brand Name Drug and certain criteria are met. Your Health Care Practitioner can submit a request to waive the difference in cost between the Allowable Amount of the Brand Name Drug and Allowable Amount of the Generic Drug. In order for this request to be reviewed, Your Health Care Practitioner must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues You experienced with the generic equivalent. Your Health Care Practitioner must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment/Coinsurance and any Deductibles will still apply. For additional information, You may access the website at www.bcbstx.com or contact customer service at the toll-free number on Your Identification Card.

Drug Coupons. If a Covered Drug was paid for using a drug manufacturer's coupon or copay card, the coupon or copay card amount will not apply to Your Deductible or out-of-pocket maximum.

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

- **Tier 1 -** includes mostly Preferred Generic Drugs and may contain some Brand Name Drugs.
- **Tier 2 -** includes mostly Non-Preferred Generic Drugs and may contain some Brand Name Drugs.
- **Tier 3 -** includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
- **Tier 4 -** includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.
- **Tier 5 -** includes Specialty Drugs and may contain some Generic Drugs.

Copayments/Coinsurance and any Deductibles for Covered Drugs on each drug tier is shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section**.** To determine the tier in which a drug is included, access the website at www.bcbstx.com or contact customer service at the toll-free number on Your Identification Card.

About Your Benefits

Covered Drug List. A list of Covered Drugs is shown on the Drug List. The HMO will periodically review the list and adjust it to modify the preferred/non-preferred drug status of new and existing drugs. Changes to the Drug List will be implemented on the next renewal date of the Group Agreement and are subject to the requirements of Texas Insurance Code, 1369.0541; however, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently. Changes to the Drug List that could have an adverse financial impact to You (i.e. drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or Prior Authorization) occur quarterly or annually consistent with Texas Insurance Code, 1369.0541. The Drug List and any modifications thereto will be made available to Members. The Covered Drug List is available by accessing the website at www.bcbstx.com or by contacting customer service at the toll-free number on Your Identification Card. The HMO may uniformly modify drug coverage under the plan at the time of coverage renewal upon at least 60 days written notice as required by applicable law.

Drug List Exception Requests. You, or Your prescribing Health Care Practitioner, can request a Drug List exception if Your drug is not on the Drug List by calling the number on the back of Your Identification Card to ask for a review. You may be required to submit a supporting statement from Your prescribing Health Care Practitioner. The HMO will conduct a review and notify You and Your prescribing Health Care Practitioner of the coverage decision within 2 business days after they receive Your request for standard review. If Your request is granted, the drug will be covered for the duration of the prescription, including refills.

If You have a health condition that may jeopardize Your life, health or ability to regain maximum function and You are undergoing a current course of treatment using a drug that is not on the Drug List, Your Health Care Practitioner may be able to ask for an expedited review process. The HMO will let You, and Your Health Care Practitioner, know the coverage decision within 1 business day, not to exceed 72 calendar hours, after receiving Your request for an expedited review. If Your request is granted, the drug will be covered for the duration of the exigency.

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

If Your coverage request is denied, the HMO will let You and Your Health Care Practitioner know why it was denied and offer You a covered alternative drug (if applicable). You may appeal the denial to an Independent Review Organization (IRO) according to the appeals process You will receive with the denial determination. You and Your prescribing Health Care Practitioner will be notified of the IRO's decision within 24 hours of an expedited review and within 72 hours for a standard review. Call the number on the back of Your Identification Card if You have any questions.

Day Supply. Benefits for Covered Drugs obtained from a Participating Pharmacy are provided up to the maximum day supply limit as shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section. The HMO has the right to determine the day supply. Payment for benefits covered by the HMO 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.

Extended Prescription Drug Supply Program. Your coverage includes benefits for up to a 90-day supply of covered maintenance type drugs purchased from a Participating Pharmacy (which may only include retail or mail order Pharmacies). Each prescription or refill is subject to the Copayment/Coinsurance and any Deductibles shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

Benefits will not be provided for more than a 30-day supply of drugs purchased from a Pharmacy not participating in the extended prescription drug supply program.

Prescription Refills. You may obtain prescription drug refills from any Participating Pharmacy. Once every 12 months, You will be able to synchronize the start time of certain Covered Drugs used for treatment and management of a chronic illness so they are refilled on the same schedule for a given time period. When necessary to fill a partial Prescription Order to permit synchronization, the HMO will prorate the Copayment due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply outlined under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section.

Refills for prescription eye drops to treat a chronic eye disease or condition will be refilled if (1) the original Prescription Order states that additional quantities of the eye drops are needed; (2) the refill does not exceed the total quantity of dosage units authorized by the prescribing Health Care Practitioner on the original Prescription Order, including refills; and (3) the refill is dispensed on or before the last day of the prescribed dosage period. The refills are allowed:

- Not earlier than the 21st day after the date a Prescription Order for a 30-day supply is dispensed; or
- Not earlier than the 42nd day after the date a Prescription Order for a 60-day supply is dispensed; or
- Not earlier than the 63rd day after the date a Prescription Order for a 90-day supply is dispensed.

Dispensing Limits. Dispensing 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, or coverage only for Members within a certain age range. 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 the HMO, 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. The HMO has the right to determine dispensing limits at its sole discretion. Payment for benefits covered by the HMO 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.

Multi-Category Split Fill Program. If this is Your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if You have not filled one of these medications recently, You may only be able to receive a partial fill (14-15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for You. If you receive a partial fill, Your Copayments and/or Coinsurance after Your deductible will be adjusted to align with the quantity of medication dispensed. If the medication is working for You and Your Physician wants You to continue on this medication, You may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the https://www.bcbstx.com/rx-drugs/pharmacy/pharmacy-programs website.

Controlled Substance Limits. In the event the HMO determines that a Member may be receiving quantities of a Controlled Substance not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary or appropriate. Restrictions may include but not be limited to a certain Provider, Pharmacy, quantity, and/or day supply for the prescribing and dispensing of the Controlled Substance. Additional Copayment/Coinsurance and any Deductible may apply.

Therapeutic Equivalent Restrictions. Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, the HMO may limit benefits to only one of the therapeutic equivalents available. If You do not choose the therapeutic equivalents that are covered under this Certificate, the drugs purchased will not be covered under any benefit level.

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

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 medications is available to You and Your Health Care Practitioner on our website at www.bcbstx.com or contact customer service at the toll-free number on Your Identification Card.

If it is Medically Necessary, coverage can be obtained for the prescription drugs subject to the step therapy program without trying an alternative medication first. In this case, Your Health Care Practitioner must contact the HMO to obtain Prior Authorization for coverage of such drug. If authorization is granted, the Health Care Practitioner will be notified, and the medication will then be covered at the applicable Copayment.

Although You may currently be on a drug that is part of the step therapy program, Your claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a therapeutic alternative medication may be required for continued coverage of the targeted drug.

Step therapy programs do not apply to prescription drug treatment for the treatment of Stage-Four Advanced, Metastatic Cancer or Associated Conditions. Coverage for prescription drug treatment for Stage-Four Advanced, Metastatic Cancer or Associated Conditions do not require You to fail to successfully respond to a different drug or provide a history of failure of a different drug, before providing coverage of a prescription drug. This applies only to a prescription drug treatment that is consistent with best practices for the treatment of Stage-Four Advanced, Metastatic Cancer or an Associated Condition; supported by peer-reviewed, evidence- based literature; and approved by the United States Food and Drug Administration.

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 the request 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, submission of the request with Urgent noted and documenting these concerns will be considered approved if we do not deny the request within 24 hours after receipt of the request. If Your step therapy exception request is denied, You have the right to request an expedited internal appeal and also

have the right to request review by an Independent Review Organization as explained under the **COMPLAINT AND APPEAL PROCEDURES** section of this Certificate of Coverage.

Prior Authorization. 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. You and Your Health Care Practitioner may access a list of the medications which require Prior Authorization on our 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 medications which require 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 by the HMO based upon its accordance with established clinical 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 explained under the **COMPLAINT AND APPEAL PROCEDURES** section of this Certificate.

Limitations and Exclusions

Pharmacy benefits are not available for*:*

1. Drugs that are not shown on the Drug List, including new to market FDA approved drugs which have not been reviewed by the HMO for inclusion on the Drug List.

2. Non-FDA approved drugs.

3. Drugs, which by law, do not require a Prescription Order, except as indicated under Preventive Care within the **PHARMACY BENEFITS** section of the Certificate of Coverage, from an authorized Health Care Practitioner, and Legend Drugs, or covered devices, for which no valid Prescription Order is obtained. (Insulin, insulin analogs, insulin pens, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of the Certificate of Coverage are covered.)

4. Prescription drugs if there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the HMO.

5. 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.

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

7. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of your Identification Card.

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

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

10. Drugs for which the Pharmacy's usual retail price to the general public is less than, or equal to, the Copayment.

11. Drugs purchased from a non-Participating Pharmacy in the Service Area.

12. Devices or Durable Medical Equipment (DME) such as, but not limited to, therapeutic devices, including support garments and other non-medicinal substances, even though such devices may require a Prescription Order. (Disposable hypodermic needles, and syringes for self-administered injections and contraceptive devices are covered). Coverage for female contraceptive devices and the rental (or, at the HMO's option the purchase) of manual or electric breast pumps is provided as indicated in the **Health Maintenance and Preventive Services** section under the **COVERED SERVICES AND BENEFITS** section of the Certificate of Coverage. However, You do have certain DME benefits available in the **Durable Medical Equipment** section under the **COVERED SERVICES AND BENEFITS** section.

13. Pharmaceuticals 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.

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

15. Any special services provided by a Pharmacy, including, but not limited to, counseling and delivery. Select vaccinations shown under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section of the Certificate of Coverage administered through certain Participating Pharmacies are an exception to this exclusion.

16. Drugs dispensed in quantities in excess of the day supply amounts indicated under the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** section, or refills of any prescriptions in excess of the number of refills specified by the authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one (1) year after the Prescription Order date.

17. Administration or injection of any drugs.

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

19. Legend Drugs which are not approved by the 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.

20. Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a Prescription Order. (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)

21. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used, or intended to be used, by intravenous, intramuscular unless approved by the FDA for self-administration, intrathecal, intraarticular injection or gastrointestinal (enteral) infusion in the home setting.

22. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative or as indicated in **Preventive Care** under the **PHARMACY BENEFITS** section of the Certificate of Coverage).

23. Allergy serum and allergy testing materials. However, You do have certain benefits available under **Allergy Care** within the **COVERED SERVICES AND BENEFITS** section of the Certificate of Coverage.

24. Athletic performance enhancement drugs.

25. Bulk powders.

26. Surgical supplies.

27. Ostomy products.

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

29. Drugs used for general anesthesia.

30. 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.

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

32. Fluoride supplements, except as required by law.

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

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

35. Drugs to treat sexual dysfunction, including but not limited to, sildenafil citrate, phentolamine, apomorphine, and alprostadil in oral and topical form.

36. Drugs for the treatment of Infertility.

37. Contraceptive drugs (except for oral contraceptive drugs), devices and related services.

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

39. Prescription Orders which do not meet the required Prior Authorization criteria.

40. Some equivalent drugs are manufactured under multiple names. In some cases, the HMO may limit benefits to only one of the equivalents available. If You do not accept the therapeutic equivalents that are covered under the Drug List, the drug purchased will not be covered under any benefit level.

41. Specialty Drugs, unless obtained through the **Specialty Pharmacy Provider**.

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

43. Shipping, handling, or delivery charges.

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

45. Brand name proton pump inhibitors.

46. Non-sedating antihistamine drugs and combination medications containing a non-sedating antihistamine and decongestant, including, but not limited to, Allegra, Claritin, Clarinex, or Zyrtec.

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

48. Repackagers, institutional packs, clinic packs, or other custom packaging.

49. Drugs without superior clinical efficacy which have lower cost therapeutic equivalents or therapeutic alternatives.

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

51. Drugs that are not considered Medically Necessary, or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

53. Drugs which are not included on the Drug List, unless specifically covered elsewhere under the Certificate of Coverage, and/or such coverage is required in accordance with applicable law or regulatory guidance.

Termination of Coverage

The Group is liable for Premium payments from the time You cease to be eligible for coverage until the end of the Contract Month in which the Group notifies the HMO that You are no longer covered by the Group, and are not eligible for coverage. The Group is required to provide coverage for You until the end of the Contract Month in which the termination notice is received by the HMO.

Subject to the preceding paragraph, coverage of any Member who ceases to be eligible as determined under the **WHO GETS BENEFITS** and **Eligibility** sections of this Certificate**,** will terminate on the last day of the Contract Month in which the Group notifies the HMO that the Member is no longer eligible for coverage, and eligibility ceases unless otherwise specified and agreed upon by the Group and the HMO. This paragraph also applies to a Dependent of Subscriber who has lost eligibility, for whatever reason, including the death of Subscriber.

If this Certificate is terminated for nonpayment of Premium, Your coverage shall be terminated effective after the last day of the Grace Period. Only Members for whom the stipulated payment is received by the HMO shall be entitled to health services covered hereunder, and then only for the Contract Month for which such payment is received. If any required payment is not received by the Premium due date, then You shall be terminated at the end of the Grace Period. You shall be responsible for the cost of services rendered to You during the Grace Period if Premium payments are not made by Group.

Your coverage is terminated upon the termination of the Group Agreement. The fact that the Group does not notify You of the termination of Your coverage, due to the termination of the Group Agreement shall not deem continuation of Your coverage beyond the date coverage terminates.

If Your coverage is terminated, Premium payments received on Your account applicable to periods after the effective date of termination shall be refunded to the Group within thirty (30) days, and neither the HMO, nor Participating Providers, shall have any further liability under this Certificate. Any claims for refunds by the Group must be made within sixty (60) days from the effective day of termination of Your coverage, or otherwise such claims shall be deemed waived.

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

Group Termination. The HMO may terminate this Certificate for the Group in the case of:

Cause	Effective Date of Termination
(1) Nonpayment of Premium	At the end of the Grace Period
(2) Fraud or intentional misrepresentation of a material fact on the part of the Group	After fifteen (15) days written notice
(3) Non-compliance by the Group with a material HMO provision relating to any employer contribution or Group participation rules	In accordance with applicable state law
(4) No Member residing or working in the Service Area	After thirty (30) days written notice
(5) Termination of membership of the Group in an association, but only if coverage is terminated uniformly without regard to a health status related factor of a covered individual	After thirty (30) days written notice

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

Non-Renewal of All Group Coverage

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

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

Member Termination. The HMO may terminate this Certificate for a Member in the case of:

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

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

COBRA Continuation Coverage

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

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

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

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

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

- Divorce;
- Subscriber's death;
- Subscriber's entitlement to Medicare benefits; or
- Cessation of covered Dependent child status under the **WHO GETS BENEFITS** and **Eligibility** sections of this Certificate.

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

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

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

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

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

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

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

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

State Continuation Coverage

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

- The death of Subscriber;
- The retirement of Subscriber; or
- Divorce.

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

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

- The end of the three (3) year period after the date of Subscriber's death or retirement;
- The end of the three (3) year period after the date of the divorce or legal separation;
- The date You become eligible for similar coverage under any substantially similar coverage under another health insurance policy, Hospital, or medical service Subscriber contract, medical practice, or other prepayment Health Benefit Plan, or by any other program; or
- The end of the period for which You have paid any applicable Premiums.

Continuation of Group Coverage Privilege. In the event Your coverage has been terminated for any reason except (i) involuntary termination for cause, or (ii) discontinuance of the Group Agreement, either in its entirety or with respect to an insured class, You shall be entitled to continuation of Group coverage if You have been continuously insured under the Certificate or under any group policy providing similar benefits which it replaces for at least three (3) consecutive months immediately prior to the termination.

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

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

- The date on which You exhaust the maximum continuation period which is:
  - if You are not eligible for COBRA continuation coverage, nine months after the date of state continuation coverage;
  - if You are covered under COBRA continuation coverage, six additional months following any period of COBRA continuation coverage;
- The date on which failure to make timely payments would terminate coverage;
- The date on which the Group coverage terminates in its entirety; or
- The date on which You are covered for similar benefits by another Hospital, surgical, medical, or major medical expense insurance policy, Hospital or medical service Subscriber contract, medical practice, other prepayment Health Benefit Plan or any other program.

Transfer of Residence

- **Within the HMO Service Area**: If Subscriber changes primary residence, notification must be made to the HMO within thirty (30) days of such change.
- **Outside the HMO Service Area**: If Subscriber no longer resides, lives, or works in the Service Area, such change will result in loss of eligibility and Subscriber must notify the HMO within thirty (30) days of such change.

Paper Check – Automatic Clearing House/Electronic Funds Transfer

BCBSTX will not charge an additional fee to a Payee if such person elects to receive the payment by paper check instead of by an automated clearinghouse transaction or other electronic funds transfer.

In addition to the definitions in the **DEFINITIONS** section of this Benefit Booklet, the following definition is applicable to this provision:

- "Payee" means individual who resides in this state, or a corporation, trust, partnership, association, or other private legal entity authorized to do business in this state that receives money as payment under an agreement.

Coordination of Benefits

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

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

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

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

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

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

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

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

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

1. The benefits of a Health Care Plan that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Certificate.

2. If according to the rules set forth below in this section the benefits of another Health Care Plan that contains a provision coordinating its benefits with this Health Care Plan would be determined before the benefits of this Health Care Plan have been determined, the benefits of the other Health Care Plan will be considered before the determination of benefits under this Health Care Plan.

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

1. Nondependent or Dependent. The Health Care Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the Health Care Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Care Plan covering the person as a dependent and primary to the Health Care Plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the Health Care Plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Health Care Plan is the primary plan. An example includes a retired employee.

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

    a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

        (1) The Health Care Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or

        (2) If both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan.

    b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

        (1) if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.

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

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

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

            - the Health Care Plan covering the custodial parent;
            - the Health Care Plan covering the spouse of the custodial parent;
            - the Health Care Plan covering the noncustodial parent; then
            - the Health Care Plan covering the spouse of the noncustodial parent.

    c. For a Dependent child covered under more than one Health Care Plan of individuals who are not the parents of the child, the provisions of **2.a or 2.b**. must determine the order of benefits as if those individuals were the parents of the child.

    d. For a Dependent child who has coverage under either or both parents' Health Care Plans and has his or her own coverage as a Dependent under a spouse's Health Care Plan, **paragraph 5**. below applies.

    e. In the event the dependent child's coverage under the spouse's Health Care Plan began on the same date as the dependent child's coverage under either or both parents' Health Care Plans, the order of benefits must be determined by applying the birthday rule in **2.a**. to the dependent child's parent(s) and the dependent's spouse.

3. Active, Retired, or Laid-off Employee. The Health Care Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Health Care Plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a

person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the Health Care Plan that covers the same person as a retired or laid-off employee or as a Dependent of a retired or laid-off employee does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if **paragraph 1.** above can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Health Care Plan, the Health Care Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Health Care Plan does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if **paragraph 1.** above can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Health Care Plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the Health Care Plan that has covered the person the shorter period is the secondary plan.

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

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

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

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

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

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

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

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

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

Reimbursement - Acts of Third Parties

HMO will provide services to You due to the act or omission of another person. However, if You are entitled to a recovery from any third party with respect to those services, You shall agree in writing, subject to the provisions of Section 140.005 of the Civil Practice and Remedies Code:

1. To reimburse HMO to the extent of the Allowable Amount that would have been charged to You for health care services if You were not covered under this Certificate. Such reimbursement must be made immediately upon collection of damages for Hospital or medical expenses by You whether by action at law, settlement or otherwise.

2. To assign to HMO a right of recovery from a third party for Hospital and medical expenses paid by HMO on Your behalf and to provide HMO with any reasonable help necessary for HMO to pursue a recovery. In addition, HMO will be entitled to recover attorneys' fees and court costs related to its subrogation efforts only if the HMO aids in the collection of damages from a third party.

Alternate Service Area Access

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

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

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

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

Assignment

This Certificate is not assignable by Group without the written consent of HMO. The coverage and any benefits under this Certificate are not assignable by any Member without the written consent of HMO.

Cancellation

Except as otherwise provided herein, HMO shall not have the right to cancel or terminate any Certificate issued to any Subscriber while the Group Agreement remains in force and effect, and while said Subscriber remains in the eligible class of employees of Group, and his Premiums are paid in accordance with the terms of this Certificate.

Clerical Error

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

Entire Certificate

This Certificate, any attachments, amendments, the Group Agreement, and the individual applications, if any, of Subscribers constitute the entire contract between the parties and as of the effective date hereof, supersede all other contracts between the parties.

Force Majeure

In the event that due to circumstances not within the commercially reasonable control of HMO, the rendering of professional or Hospital Services provided under this Certificate is delayed or rendered impractical, HMO shall

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

Form or Content of Certificate

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

Gender

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

Identity Theft Protection

As a Member, HMO makes available at no additional cost to You identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect Your information. These identity theft protection services are currently provided by HMO's designated outside vendor and acceptance or declination of these services is optional to Member. Members who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbstx.com or telephonically by calling the phone number on the back of Your identification card. Services may automatically end when the person is no longer an eligible Member. Services may change or be discontinued at any time with reasonable notice. HMO does not guarantee that a particular vendor or service will be available at any given time.

Incontestability

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

Interpretation of Certificate

The laws of the state of Texas shall be applied to interpretations of this Certificate. Where applicable, the interpretation of this Certificate shall be guided by the direct-service nature of HMO's operations as opposed to a health insurance program. If the Certificate contains any provision not in conformity with the Texas Health Maintenance Organization Act or other applicable laws, the Certificate shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas Health Maintenance Organization Act and other applicable laws. Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

Limitation of Liability

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

Member Data Sharing

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

Modifications

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

Notice

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

HMO, or Group by agreement between HMO and Group, may send You notices under this Certificate. These notices may be delivered:

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

Patient/Provider Relationship

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

Refund of Benefit Payments

If Your Group's benefit plan or BCBSTX pays benefits for Covered Services incurred by You or Your Dependents and it is found that the payment was more than it should have been, or 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, Participating Providers or non-Participating Providers.

If no refund is received, Your Group's benefit plan and/or BCBSTX (in its capacity as HMO, insurer, or administrator) have the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

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

(b) any future benefit payment made to any person or entity under another BCBSTX-administered ASO 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 non-Participating 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.

Relationship of Parties

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

Reports and Records

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

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

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

Rescission

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. A retroactive cancellation or discontinuance of coverage due to failure to timely pay required Premiums or contributions toward the cost of coverage (including COBRA premiums), a cancellation or discontinuance initiated by You or Your authorized representative or a prospective cancellation or discontinuance of coverage is not considered a Rescission. Rescission is subject to 30 days' prior notification and is retroactive to the Effective Date. In the event of such cancellation, HMO may deduct from the Premium refund any amounts made in claim payments during this period and You may be liable for any claims payment amount greater than the total amount of Premiums paid during the period for which cancellation is affected. At any time when HMO is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Certificate of Coverage, HMO may at its option make an offer to reform the Certificate of Coverage already in force and/or change the rating category/level. In the event of reformation, the Certificate of Coverage will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. Please call HMO at the toll-free number listed on the back of Your identification card for additional information regarding Your appeal rights concerning Rescission and/or reformation. 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.

Subtitles

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

NOTICES

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

BlueCross BlueShield of Texas

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We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator 300 E. Randolph St. 35th Floor Chicago, Illinois 60601	Phone: TTY/TDD: Fax:	855-664-7270 (voicemail) 855-661-6965 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services 200 Independence Avenue SW Room 509F, HHH Building 1019 Washington, DC 20201	Phone: TTY/TDD: Complaint Portal: Complaint Forms:	800-368-1019 800-537-7697 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf http://www.hhs.gov/ocr/office/file/index.html

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

NOTICE

Adverse Benefit Determinations

This Notice is to advise You that in addition to the processes outlined in **COMPLAINT AND APPEAL PROCEDURES** section of the **Certificate** and in the **Plan Description and Member Handbook,** you have the right to seek and obtain a review by HMO of any Adverse Benefit Determinations made by HMO in accordance with the benefits and procedures detailed in Your Certificate.

Review of Claim Determinations

Claim Determinations. When HMO receives a properly submitted claim, it has authority and discretion under the plan to interpret and determine benefits in accordance with the plan provisions. You have the right to seek and obtain a review by HMO of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by HMO in accordance with the benefits and procedures detailed in Your plan.

If a Claim is Denied or Not Paid in Full. If the claim is denied in whole or in part, You will receive a written notice from HMO 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 HMO's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of Your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by HMO;
- 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 Prior Authorization, as described in this Certificate, 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 HMO that a service has been rendered or furnished to You. This notification must include full details of the service received, including Your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which HMO may request in connection with services rendered to You.

NOTICE

Adverse Benefit Determinations

Urgent Care Clinical Claims*

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

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

Pre-Service Claims

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

* This period may be extended one time by HMO for up to 15 days, provided that HMO 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 HMO expects to render a decision.

NOTICE

Adverse Benefit Determinations

Post-Service Claims

Type of Notice or Extension	Timing
If Your claim is incomplete, HMO must notify You within:	**30 days**
If You are notified that Your claim is incomplete, You must then provide completed claim information to HMO within:	**45 days** after receiving notice
HMO must notify You of any adverse claim determination:	
if the initial claim is complete, within:	**30 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

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

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

Note: If HMO 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. This notice will explain Your rights to expedited appeal and immediate review by an Independent Review Organization.

Claim Appeal Procedures

Claim Appeal Procedures – Definitions. An "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by HMO and HMO reduces or terminates such treatment (other than by amendment or termination of the Employer's benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

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

Expedited Clinical Appeals. If Your situation meets the definition of an expedited clinical appeal, You may be entitled to an appeal on an expedited basis. An "expedited clinical appeal" is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of emergency care or continued hospitalization, or the discontinuance by HMO 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, HMO 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, HMO 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. HMO 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 HMO.

NOTICE

Adverse Benefit Determinations

How to Appeal to an Adverse Benefit Determination. You have the right to seek and obtain a review of any determination of a claim, any determination of a request for Prior Authorization, or any other determination made by HMO 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 HMO at the number on the back of Your identification card. If You believe HMO incorrectly denied all or part of Your benefits, You may have Your claim reviewed. HMO 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 HMO to request a claim review. HMO 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

- HMO will honor telephone requests for information; however, such inquiries will not constitute a request for review.
- In support of Your claim review, You have the option of presenting evidence and testimony to the HMO. 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.

During the course of Your internal appeal(s), HMO will provide You or Your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by HMO in connection with the appealed claim as well as any new or additional rationale for a denial at the internal appeals stage. Such new or additional evidence or rationale will be provided to You or Your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give You a reasonable opportunity to respond. HMO may extend the time period described in this Certificate for its final decision on appeal to provide You with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal will be conducted by individuals associated with HMO and/or by external advisors, but who were not involved in making the initial denial of Your claim. No deference will be given to the initial Adverse Determination. Before You or Your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the HMO.

- If You have any questions about the claims procedures or the review procedure, write to the HMO's Administrative Office or call the toll-free Customer Service Helpline number shown on Your identification card.
- If You have a claim for benefits which is denied or ignored, in whole or in part, and Your health plan is governed by the Employee Retirement Income Security Act (ERISA), You have the right to bring civil action under 502 (a) of ERISA.

Timing of Appeal Determinations

HMO 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 HMO.

HMO 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 HMO.

If You Need Assistance. If You have any questions about the claims procedures or the review procedure, write or call the HMO at 1-877-299-2377. The 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

NOTICE

Adverse Benefit Determinations

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

HMO 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, orally of its determination followed-up by a written notice of the determination.

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

- The reasons for the determination;
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol 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 HMO's external review processes (and how to initiate an external review) and a
- statement of Your right, if any, to bring a civil action under Section 502(a) of 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 HMO;
- 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 HMO denies Your appeal, in whole or in part or You do not receive timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision.

Note: You have the right to immediate review by an Independent Review Organization and do not have to comply with the internal appeal process in life-threatening or urgent care circumstances, if HMO has discontinued prescription drugs or intravenous infusions for which You were receiving health benefits under the plan, or if You do not receive a timely decision on Your appeal.

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

External Review Criteria

External Review is available for Adverse Benefit Determinations and Final Adverse Benefit Determinations that involve rescission and determinations that involve medical judgment including, but not limited to, those based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness

or a covered benefit; determinations that a treatment is experimental or investigational; determinations whether you are entitled to a reasonable alternative standard for a reward under a wellness program; or a determination of compliance with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act

Standard External Review

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

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

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

   The IRO must provide the following:

   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
   c. Within five business days after the date of assignment of the IRO, the HMO must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit

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

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

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

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

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

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

   (1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
   (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
   (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
   (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the HMO or you or your authorized representative;
(6) A statement that judicial review may be available to you or your authorized representative; and
(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

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

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

Expedited External Review

1. **Request for expedited external review.** You may request for an expedited external review with the HMO at the time you receive:
   a. An Adverse Benefit Determination, if the Adverse Benefit Determination involved a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
   b. A Final Internal Adverse Benefit Determination, if the determination involved a medical condition of yours for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
2. **Preliminary review**. Immediately upon receipt of the request for expedited external review, the HMO must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. The HMO must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.
3. **Referral to Independent Review Organization (IRO)**. Upon a determination that a request is eligible for external review following the preliminary review, the HMO will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. The HMO must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the HMO's internal claims and appeals process.
4. **Notice of final external review decision**. The assigned IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing verbal notice, the assigned IRO must provide written confirmation of the decision to the HMO and you or your authorized representative.

NOTICE

Adverse Benefit Determinations

Exhaustion

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

You will be deemed to have exhausted the internal review process and may request external review if the HMO waives the internal review process or the HMO has failed to comply with the internal claims and appeals process other than a de minimis failure. In the event you have been deemed to exhaust the internal review process due to the failure by the HMO to comply with the internal claims and appeals process other than a de minimis failure, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

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

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

NOTICE

OUT-OF-NETWORK PHYSICIANS AND PROVIDERS

This notice is to advise you of your rights regarding services from out-of-network physicians and providers. Out-of-network physicians and providers are not part of the HMO's network of participating providers.

A health maintenance organization (HMO) plan does not provide benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Certificate of Coverage and below.

- You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers*).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network physician or provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that you only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: https://www.bcbstx.com/find-a-doctor-or-hospital or by calling 1-877-299-2377 for assistance in finding available network physicians and providers. If you relied upon materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your HMO contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this Plan has either a mastectomy or a lymph node dissection, this Plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy
(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility, continued eligibility, or fail to renew this Plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy - Enrollment

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) All stages of the reconstruction of the breast upon which the mastectomy was performed;
(b) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
(c) Prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Deductibles, coinsurance, and copayment amounts will be the same as those applied to other similarly covered medical services as shown under the Schedule of Copayments and Benefit Limits.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan, or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

NOTICE OF CERTAIN MANDATORY BENEFITS

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) A physical examination for the detection of prostate cancer; and
(b) A prostate-specific antigen test for each covered male who is:
  (1) At least 50 years of age; or
  (2) At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and
(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance, and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse, or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Since we provide in-home post-delivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary, or (b) the mother requests the inpatient stay.

Prohibitions. We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother, if the period recommended by the physician, does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

NOTICE OF CERTAIN MANDATORY BENEFITS

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 45 years of age or older, and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of: (a) a fecal occult blood test performed annually, and a flexible sigmoidoscopy performed every five years, or (b) a colonoscopy performed every 10 years.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening, or a screening using liquid-based cytology methods, as approved by the FDA, alone, or in combination with, a test approved by the FDA for the detection of the human papillomavirus.

Treatment of Acquired Brain Injury

Your health benefit plan coverage for an acquired brain injury includes the following services:

(a) Cognitive rehabilitation therapy;
(b) Cognitive communication therapy;
(c) Neurocognitive therapy and rehabilitation;
(d) Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment;
(e) Neurofeedback therapy, remediation;
(f) Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
(g) Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

If any person covered by this plan has questions concerning the information above, please call Blue Cross and Blue Shield of Texas at 1-877-299-2377 or write us at P.O. Box 660044, Dallas, Texas 75266-0044.

NOTICE

INTER-PLAN ARRANGEMENTS NOTICE

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

Inter-Plan Arrangements

Out-of-Area Services

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation (herein called "HMO") has a variety of relationships with other Blue Cross and/or Blue Shield Plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter- Plan Arrangements." These Inter- Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you obtain healthcare services outside of our Service Area, the claims for these services may be processed through one of these Inter- Plan Arrangements.

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

We cover only limited healthcare services received outside of our Service Area. As used in this section, "Covered Services" include Emergency Care, Urgent Care, and follow- up care obtained outside the geographic area we serve. Any other services will not be covered when processed through any Inter- Plan Arrangements, unless authorized by your Primary Care Physician/Practitioner ("PCP")/HMO.

A. BlueCard® Program

Under the BlueCard Program, when you obtain Covered Services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However the Host Blue is responsible for contracting with and generally handling all interactions with its Participating healthcare Providers.

The BlueCard Program enables you to obtain Covered Services, as defined above, from a healthcare Provider participating with a Host Blue, where available. The Participating healthcare Provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment amount indicated in the Certificate of Coverage, Schedule of Copayments and Benefit Limits.

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

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

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

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

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

NOTICE

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, HMO will include any such surcharge, tax or other fee as part of the claim charge passed on to you. If federal law or any state laws mandate other liability calculation methods, including a surcharge, HMO would then calculate your liability for any Covered Services according to the applicable law in effect when care is received.

B. Non-Participating Healthcare Providers outside our Service Area

Liability Calculation

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

For Emergency Care and Urgent Care services received from non- Participating Providers within the state of Texas, please refer to the "Emergency Services" section of this benefit booklet.

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

C. Blue Cross Blue Shield Global Core

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

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

- **Inpatient Services**

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

  You must contact Blue Cross and Blue Shield of Texas to obtain Prior Authorization for non- emergency inpatient services.

- **Outpatient Services**

  Physicians, Urgent Care centers and other outpatient providers located outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

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

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

HANDBOOK

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

This Plan is offered by the following organization,
which operates under Chapter 843
of the Texas Insurance Code:

BLUE CROSS AND BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION
1001 E. Lookout Drive
Richardson, TX 75082

Plan Description and Member Handbook

The following is a brief summary of your benefits and describes your rights and responsibilities under this health care plan. This document may be delivered to You electronically. Any notices included with this document may be sent to you electronically by the HMO, or the Group by agreement between the HMO and the Group. Paper copies are available upon request. You can find more complete information about this health care plan in the Certificate of Coverage documents (COC) which you will receive after you enroll.

We want you to be satisfied with your new health care program. If you would like more information about the plan, a Customer Service representative will be happy to help you. Call Customer Service Monday through Friday from 7:30 a.m. to 6:00 p.m. CST at 1-877-299-2377. You may also write the HMO at:

HMO Customer Service
P.O. Box 660044
Dallas, Texas 75266-0044

Again, thank you for considering us for your health care coverage.

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

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MEDICALLY NECESSARY COVERED SERVICES AND BENEFITS

The COC contains specific information regarding your health care benefits, copayments, any other amounts due, limitations, and exclusions. You will receive this document after you enroll. To obtain the most from your health care coverage, please take time to review your COC, Benefit Highlights and attachments carefully and keep them for reference.

During enrollment, you will select a primary care physician/practitioner (PCP) for yourself and one for each of your covered dependents. Your PCP can provide most of your health care needs. A PCP may be a family or general practitioner, advanced practice nurse, physician assistant, internist, pediatrician or obstetrician-gynecologist (OB-GYN). Please see the "Receiving Care" section below for more information about PCPs.

The copayment and any other coinsurance or deductible amount is determined by Your plan. Consumer Choice plans do not include all state-mandated health insurance benefits, which means these plans may include deductibles and benefit limits that are not included on other plans.

Hospitalization

If you need to be hospitalized, your PCP, or participating OB/GYN, can arrange for your care at a local participating hospital. Your PCP, or participating OB/GYN, will make the necessary arrangements (including referrals) and keep you informed. The HMO shall review the referral request and issue a determination indicating whether proposed services have obtained Prior Authorization within 24 hours of the request by the PCP, or participating OB/GYN,. You may have to pay a copayment and any other applicable coinsurance or deductibles for some of these services, depending on your plan.

During an inpatient stay at a participating hospital, skilled nursing facility, or other participating facility, it may be appropriate for a physician other than your PCP to direct and oversee your care, if your PCP does not do so. However, upon discharge, you must return to the care of your PCP or have your PCP coordinate care that may be medically necessary.

When you think you need hospital care, in non-emergency situations, first call your PCP. Special rules apply in emergency situations or in cases where you are out of the area (see the "Emergency Care" section below.)

Other Medical Services

In addition to PCPs, specialists, and hospitals, the network includes other health care professionals to meet your needs. If you need diagnostic testing, laboratory services, or other health care services, your PCP or participating OB/GYN will coordinate your care or refer you to an appropriate setting. You may have to pay a copayment and any other applicable coinsurance or deductibles for some of these services, depending on your plan.

Preventive Care

Preventive care is a key part of your plan, which emphasizes staying healthy by covering:

- Well-childcare, including immunizations;
- Prenatal and postnatal care;
- Hearing loss screenings through 24 months;
- Periodic health assessments;
- Eye and ear screenings;
- Annual well-woman exams, including, but not limited to, a conventional Pap smear;
- Annual screening mammograms for females age 35 and over, or females with other risk factors;
- Bone mass measurement for osteoporosis;

- Colorectal cancer exams, preventive services, and lab tests that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") for persons 45 years of age and older
- Depending on your plan, any other evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Task Force (“USPSTF”) or as required by state law.

Behavioral Health Care

Your mental health benefits include outpatient, and depending on your plan, inpatient visits for crisis intervention and evaluation. Please refer to your COC for additional information. To access mental health services, call the designated behavioral health vendor listed on the back of your ID card.

Benefits and coverage for behavioral health services are provided under the same terms and conditions applicable to this Plan’s medical and surgical benefits and coverage. The HMO will not impose treatment limitations on benefits for behavioral health services that are generally more restrictive than treatment limitations imposed on coverage of benefits for medical or surgical services.

Prescription Drugs

Depending on your plan, you may have coverage for prescription drugs. To find out which prescription drugs are covered under a plan, you can review the applicable drug list at https://www.bcbstx.com.

REMEMBER:
- Your PCP, or participating OB/GYN, will arrange for specialty care or hospitalization.
- Preventive care is an important part of your program to help you stay healthy. These services can be provided or arranged by your PCP.
- Usually a copayment and any applicable coinsurance or deductible is all you will be responsible for when you obtain services provided or arranged by your PCP.
- You won’t have to file claims for services received from participating providers.

EMERGENCY CARE, AFTER HOURS CARE, AND URGENT CARE

Medical Emergencies

Emergency care is defined as health care services provided in a participating or non-participating hospital emergency facility, freestanding emergency medical care facility, or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the patient’s health in serious jeopardy, cause serious impairment to a bodily function, cause serious dysfunction of any organ or part of the body, cause serious disfigurement or, in the case of a pregnant woman, cause serious jeopardy to the health of the fetus.

In a medical emergency, seek care immediately. Present your ID card to the hospital emergency room or comparable facility. You or a family member should call your PCP within 48 hours, or as soon as possible, after receiving emergency care. This call is important so that your PCP can coordinate or provide any follow-up care required as a result of a medical emergency.

REMEMBER:
- In an emergency, seek care immediately.
- You or a family member should call your PCP within 48 hours, or as soon as possible, after receiving emergency care.

If post stabilization care is required after an emergency care condition has been treated and stabilized, the treating physician or provider will contact the HMO or its designee, who must approve or deny such treatment within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient. In no case shall approval or denial exceed one hour from the time of the request.

After Hours Care

HMO participating providers have systems in place to respond to your needs when their business offices are closed. These systems may include the use of an answering service or a recorded message informing patients on how to access further care.

Urgent Care Services

Urgent care services are covered when rendered by a participating urgent care center provider for the immediate treatment of a medical condition that requires prompt medical attention, but where a brief time lapse before receiving services will not endanger life, or permanent health, and does not require emergency care services. A PCP referral is not required.

Retail Health Clinics

Retail health clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional PCP office visit, urgent care visit, or emergency care visit. A PCP referral is not required to obtain covered services.

Out-of-Area Services and Benefits

Emergency Services Outside the Service Area

In an emergency, go directly to the nearest hospital. If you are outside the service area and require medical care, you are covered for emergency services only.

Urgent Care Outside the Service Area

When you are traveling outside of Texas and you need urgent care that cannot be postponed until you return home, the BlueCard® Program gives you the ability to obtain health care services through a Blue Cross and Blue Shield affiliated physician or hospital outside of Texas.

Follow these easy steps:

1. Locate a participating provider by calling BlueCard Access at 1-800-810-BLUE (2583) or visit the BlueCard Doctor and Hospital Finder website (www.bcbs.com).
2. Call your PCP for referrals and for care requiring Prior Authorization.
3. Schedule an appointment directly with the provider.
4. Present your ID card.
5. Pay any applicable copayments, coinsurance or deductible.
6. Discuss follow-up care with your PCP.

Away From Home Care® Program

If you (or a covered dependent) will be temporarily residing outside of Texas, in a participating location, for at least 90 days, you may be eligible to obtain covered services from a Blue Cross and Blue Shield Association affiliated HMO. Under the Away From Home Care (AFHC) Program, you retain your coverage under the HMO.

To apply, call the home plan AFHC Coordinator at 1-888-522-2396 before you leave your service area, who will locate the HMO near your (or your dependent's) temporary location and process your request.

When you arrive at your new location, call the Host HMO AFHC Program Coordinator and receive information about the host HMO, including a list of physicians and benefits you are entitled to. The benefits available and requirements for accessing services outside of Texas may not be identical to those under your current HMO plan. When returning to the home plan service area, use the home plan PCP and receive home plan benefits.

OUT-OF-NETWORK FACILITY BASED PROVIDERS AND DIAGNOSTIC IMAGING AND LAB PROVIDERS

In some instances, you may not have the ability to choose a participating provider, such as when you receive services from a non-participating facility-based provider in a participating facility, or when you receive services from a non-participating laboratory or diagnostic imaging facility in connection with care provided by your participating provider. In these instances, your services may be covered, and you would not be responsible for any amounts beyond the copayment and any applicable coinsurance or deductibles. If you receive a bill from a non-participating provider in such circumstances, please call HMO. If you elect to use non-participating providers for non-emergency care services and supplies available from participating providers, benefits will not be covered.

YOUR FINANCIAL RESPONSIBILITIES

BCBSTX requires a premium from you (or your employer) as a condition of coverage. A copayment and any applicable coinsurance or deductible may be due at the time a participating provider renders service. Certain copayment amounts and any applicable coinsurance or deductible and the corresponding types of services are listed on your ID card. For a complete list, please refer to the Schedule of Copayments and Benefit Limits in your COC. The copayment and any other coinsurance or deductible amount are determined by your plan. Consumer Choice plans do not include all state mandated health insurance benefits, which means these plans may include deductibles and benefit limits that are not included on other plans. Also, you will have to pay for services not covered by HMO.

HMO network physicians and providers have agreed to look only to the HMO, and not to its members, for payment of covered services. Usually, you are expected to pay nothing more than a copayment and any applicable coinsurance or deductible to participating providers. You should not receive a bill for services received from participating providers. If this occurs, call Customer Service to help determine if the service is a covered benefit and/or to correct the problem.

LIMITATIONS AND EXCLUSIONS

Your COC contains specific information including limitations and exclusions. If prescription drugs are covered your COC will included prescription drug benefit exclusions and limitations. The Benefit Highlights also include a summary of limitation and exclusions.

PRIOR AUTHORIZATION REQUIREMENTS, REFERRAL PROCEDURES, AND OTHER REVIEW REQUIREMENTS

Except for emergency care, your PCP or OB/GYN must authorize all referrals in advance. When your PCP refers you for care, this helps ensure that you receive care that is medically necessary and appropriate. If your PCP, or OB/GYN, cannot render the services you require, then the PCP, or OB/GYN, will refer you to the provider(s) you need. Any referral services will be subject to the terms, conditions, limitations, and exclusions of the HMO plan. Please see the **"**Receiving Care**"** section below for more information about PCPs.

Emergency care services for screening and stabilization do not require Prior Authorization. Routine requests for inpatient admissions receive Prior Authorization by registered nurses who utilize a system of clinical protocols and criteria to determine the following:

- Medical necessity of the requested care;
- Appropriateness of the location and level of care;
- Appropriateness of the length of stay; and/or
- Assignment of the next anticipated review point.

Concurrent Review

The HMO supports the review of requests for continued services including inpatient hospital admissions. Concurrent review is conducted both telephonically and via onsite review at selected facilities. Reviews are conducted by registered nurses and include the following:

- Evaluation for appropriateness (medical necessity/level of care/length of stay);
- Evaluation and coordination of discharge planning requirements;
- Referral to Case Management or Disease Management Programs; and/or
- Identification of potential quality of care issues.

Retrospective Review

The HMO conducts reviews after services have been provided to the patient. Retrospective review includes a medical necessity evaluation of the care/service provided to a member, and of physician compliance to the Utilization/Case Management Program Requirements.

Case Management Review

The Case Management Department facilitates a collaborative process to access, plan, implement, coordinate, monitor, evaluate options, and/or service to meet a member's health care needs through communication and available resources to promote appropriate, cost-effective outcomes.

CONTINUITY OF TREATMENT IN THE EVENT OF TERMINATION OF A NETWORK PROVIDER

If you receive notice that your provider is no longer participating with the HMO, it is important to understand that there are special circumstances that allow the provider to continue treatment for a limited time. Except for reasons of medical competence or professional behavior, termination does not release the HMO from the obligation to reimburse a provider who is treating you if you have a disability, acute condition, life-threatening illness, or a pregnancy which has passed the 13th week.

If your provider reasonably believes that discontinuing the care that he or she is providing may cause harm to you, he or she must identify the special circumstances to the HMO, and request that you be allowed to continue treatment. Continuity of treatment may last (i) for up to 90 days from the provider's termination date, (ii) for up to nine months in the case of a member who at the time of provider termination has been diagnosed with a terminal illness, or (iii) for a member who at the time of the termination is past the 13th week of pregnancy, through the delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

COMPLAINT PROCEDURE: APPEAL OF ADVERSE DETERMINATION; INDEPENDENT REVIEW ORGANIZATION PROCESS; AND NON-RETALIATION

Claim or Benefit Reconsideration

If a claim or request for benefits is partially or completely denied, you will receive a written explanation of the reason for the denial and be entitled to a full review. If you wish to request a review or have a question regarding the explanation of benefits, please call or write Customer Service at the telephone number or address on the back of your ID card. If you are still not satisfied, you may request an appeal of the decision, or file a complaint. You may obtain a review of the denial by following the procedures set forth below and more fully in the Complaint and Appeal Procedures in the COC.

Complaints

There may be times when you find that you don't agree with a particular HMO policy, procedure, or benefit decision, or you are not satisfied with some aspect of the treatment by a participating provider. We encourage you to communicate your dissatisfaction promptly and directly to the source of the problem.

The goal of Customer Service is to prevent small problems from becoming large issues. To express a complaint regarding any aspect of the HMO program, please call or write Customer Service.

If an inquiry is not resolved promptly to your satisfaction, it will be handled according to the complaint procedure described below.

Complaint Procedure

A complaint is any dissatisfaction expressed orally or in writing to the HMO regarding any aspect of our operation, such as plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. A complaint is not a misunderstanding or problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to your satisfaction.

Also, a complaint does not include your oral or written dissatisfaction or disagreement with an adverse determination (a denial of care or service based on a lack of medical necessity or appropriateness of care).

Within five days of receiving your oral or written complaint, the HMO will send you a letter acknowledging the complaint, together with a description of our complaint process and timeframes. If the complaint was received orally, we will send a complaint form that you must fill out and return for prompt resolution.

After receiving your written complaint or the written complaint form, the HMO will investigate your concerns and send you a letter outlining and explaining the resolution. The letter includes a statement of the specific medical and contractual reasons for the resolution, including any benefit exclusion, limitation, or medical circumstance, additional information required to adjudicate a claim, if applicable, and the specialization of any provider consulted. The total time for acknowledging, investigating, and resolving your written complaint will not exceed thirty calendar days from the date the HMO receives your written complaint or complaint form.

If the complaint is not resolved to your satisfaction, you have the right to dispute the resolution by following the complaint appeals process. A full description of the complaint appeals process will accompany the complaint resolution.

Investigation and resolution of complaints concerning emergencies or denials of the continued hospitalization are concluded in accordance with the medical or dental immediacy of the case, not to exceed one business day from receipt of the complaint.

The HMO is prohibited from retaliating against an individual who has filed a complaint against or appealed a decision of the HMO. Also, we are prohibited from retaliating against a physician or provider because the physician or provider has, on your behalf, reasonably filed a complaint against or appealed a decision of the HMO.

Complaint Appeals to the HMO

The complaint appeals process allows you to dispute the complaint resolution before a complaint appeal panel. Following receipt of your written request for a complaint appeal, you may dispute the complaint resolution in person, in writing, by telephone, or by other technological methods. The HMO will send you an acknowledgement letter no later than five business days after the date of receipt of your written request for appeal.

The complaint appeal panel is an advisory committee composed of an equal number of the HMO staff, physicians, or other providers, and others covered by the HMO. Participants of the complaint appeal panel will not have been involved in the previously disputed decisions related to the complaint. Experienced physicians or other providers review the case; the resolution recommended by the panel is independent of any prior physician or provider determinations. If you are disputing specialty care, the appeal panel must include a person who is a specialist in the field of care being disputed. Persons selected to participate on the complaint appeal panel are not the HMO staff. The appeals process will not exceed thirty calendar days from the date the HMO receives the written request for appeal.

No later than the fifth business day before the scheduled meeting of the panel, the HMO will provide you, or your designated representative, with:

- Any documents to be presented to the panel by the HMO staff;
- The specialization of any physicians or providers consulted during the investigation;
- The name and affiliation of each HMO representative on the panel; and
- The date and location of the hearing.

You are entitled to:

- Appear in person by conference call, other appropriate technology, or through a representative, if the complainant is a minor or disabled, before the complaint appeal panel;
- Present written or oral information to the appeal panel;
- Present alternative expert testimony; and
- Request the presence of and question any person responsible for making the prior determination that resulted in the appeal.

You will receive a written decision of the complaint appeal. When appropriate, it includes a specific medical determination, clinical basis, contractual criteria used to reach the final decision, and the toll-free telephone number and address of the Texas Department of Insurance.

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

- Information relied upon in making the benefit determination;
- Information submitted, considered or generated in the course of making the benefit determination, and whether or not it was relied upon in making the benefit determination;
- Descriptions of the administrative process and safeguards used in making the benefit determination;
- Records of any independent reviews conducted by the HMO;
- Medical judgments, including determinations about whether a particular service is experimental, investigational, or not medically necessary or appropriate; and

- Expert advice and consultation obtained by the HMO in connection with the denied claim, and whether or not the advice was relied upon in making the benefit determination.

Filing Complaints with the Texas Department of Insurance

Any person, including those who have attempted to resolve complaints through the HMO's complaint process, who is dissatisfied with the resolution, may report their dissatisfaction to the Texas Department of Insurance, Consumer Protection (111-1A), P.O. Box 149091, Austin, Texas 78714-9091.

There are two methods of filing a TDI complaint:

- Via mail; or
- Via online at www.TDI.texas.gov

The Texas Department of Insurance will investigate complaints against the HMO within sixty (60) days after receiving the complaint. The time necessary to complete an investigation may be extended if:

- Additional information is needed;
- An on-site review is necessary;
- Complainant, the HMO, or the physician or provider does not provide all documentation necessary to complete the investigation; or
- Other circumstances beyond the control of the Texas Department of Insurance occur.

Appeal of Adverse Determinations

An adverse determination is a determination made by the HMO, or a utilization review agent physician, that health care services provided, or proposed to be provided, are experimental, investigational, or not medically necessary. An adverse determination is not a denial of health care services due to the failure to request prospective or concurrent utilization review. In life-threatening or urgent care circumstances, if the HMO has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the COC, or if you do not receive a timely decision, you are entitled to an immediate appeal to an independent review organization ("IRO") and are not required to comply with the HMO's appeal of an adverse determination process. An IRO is an organization independent of the HMO which may perform a final administrative review of an adverse determination made by the HMO.

The HMO maintains an internal appeal system that provides reasonable procedures for the resolution of an oral or written appeal concerning dissatisfaction or disagreement with an adverse determination. The appeal of an adverse determination process is not part of the complaint process. You, your designated representative, your physician, or provider may initiate an appeal of an adverse determination.

When services provided, or proposed to be provided, are deemed experimental, investigational, or not medically necessary, the HMO or a utilization review agent will regard the expression of dissatisfaction or disagreement as an appeal of an adverse determination.

Within five working days of your appeal request, the HMO will send you a letter acknowledging the date of receipt of the appeal and a list of documents you must submit. For oral appeals, we will also send you a one-page appeal form for completion that must be returned to the HMO. The HMO will provide a review by a board-certified physician or provider who has not already reviewed your case, and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. We have thirty days from your appeal request to provide you written notice of the appeal determination.

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

You will receive a written decision of the appeal that will include dental, medical, and contractual reasons for the resolution; clinical basis for the decision; specialization of provider consulted; notice of your right to have an independent review organization review the denial; and TDI's toll-free telephone number and address.

Expedited Appeal of Adverse Determination Procedures

Investigation and resolution of appeals relating to ongoing emergencies or denials of continued hospital stays, or the discontinuation by the HMO of prescription drugs or intravenous infusions for which you were receiving health benefits under the COC, are referred directly to an expedited appeal process and will be concluded in accordance with the medical or dental immediacy of the case. In no event will the request for an expedited appeal exceed one business day from the date all information necessary to complete the appeal request is received, or three calendar days of the appeal request, whichever is sooner. The HMO will provide a review by a board-certified physician or provider who has not already reviewed your case, and who is of the same or similar specialty as typically manages the medical condition, procedure, or treatment under review. That physician or provider may interview you and will render a decision on the appeal. The initial notice of the decision may be made orally with written notice of the determination following within three days.

Appeals Process to Independent Review Organization

An independent review organization is an organization independent of the HMO that may perform a final administrative review of an adverse determination made by us.

In a circumstance involving a life-threatening or urgent care circumstances, if the HMO has discontinued coverage of prescription drugs or intravenous infusion for which you were receiving health benefits under the COC, or if you do not receive a timely decision, you are entitled to an immediate appeal to an independent review organization rather than going through the HMO's appeal of an adverse determination process.

The independent review organization process is not part of the complaint process but is available only for appeals of adverse determination.

You may request a review of an appeal of an adverse determination by the independent review organization. The HMO will adhere to the following guidelines/criteria:

- Provide you, your designated representative, or your provider of record, information on how to appeal the denial of an adverse determination to an independent review organization;
- Provide this information at the initial adverse determination and the denial of the appeal;
- Provide the appropriate form to complete;
- You, a designated representative, or your provider of record, must complete the form and return it to the HMO to begin the independent review process;
- In life-threatening or urgent care situations, or if the HMO has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the COC, you, your designated representative, or provider of record, may contact the HMO by telephone to request the review;
- Submit medical records, names of providers, and any documentation pertinent to the adverse determination to the independent review organization;
- Comply with the determination by the independent review organization; and
- Pay for the independent review.

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

- Information relied upon in making the benefit determination;
- Information submitted, considered, or generated in the course of making the benefit determination, and whether or not it was relied upon in making the benefit determination;
- Descriptions of the administrative process and safeguards used in making the benefit determination;
- Records of any independent reviews conducted by the HMO;
- Medical judgments, including determinations about whether a particular service is experimental, investigational, or not medically necessary or appropriate; and
- Expert advice and consultation obtained by the HMO in connection with the denied claim, and whether or not the advice was relied upon in making the benefit determination.

The appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under the law, if exhausting the procedures of the HMO's process for appeal and review places your health in serious jeopardy.

NETWORK PROVIDERS

To find out more about the HMO's contracting providers, refer to the website at https://www.bcbstx.com/find-a-doctor-or-hospital for Provider Finder®, an Internet-based provider directory. It has important information about the locations and availability of providers, restrictions on accessibility, referrals to specialists, and information about limited provider networks. You may also request a hard copy or electronic copy of the provider directory, which is updated quarterly, by calling or writing Customer Service. The directories can also be found at https://www.bcbstx.com/find-a-doctor-or-hospital. Upon admission to an inpatient facility, (e.g. hospital or skilled nursing facility), a participating physician other than your primary care physician/practitioner may direct and oversee your care.

Your PCP will be the one you call when you need medical advice, when you are sick, and when you need preventive care such as immunizations. Your PCP may also be part of a "network" or association of medical professionals and facilities that work together to provide health care services in a timely, efficient, and cost-effective manner. That means when you choose your PCP, you are also choosing a network, and in most instances, you are not allowed to receive services from any physician or health care professional, including your obstetrician-gynecologist (OB-GYN), that is not also part of your PCP's network. You will not be able to select any physician or health care professional outside of your PCP's network, even though that physician or health care provider is listed with your health plan. If you see any physician or provider outside of that network, even if the name of such physician or provider is listed in the provider directory, the cost of such services will not be covered under your health plan.

Your PCP will play a key role in the delivery of your health care. The network to which your PCP belongs will provide or arrange for all your care, so make sure that your PCP's network includes the specialists and hospitals that you prefer.

If your PCP changes networks, you will be notified and will receive an updated ID card. You and your covered dependents may select the same or a different provider network, and the same or a different PCP within the network.

DIRECT ACCESS FOR OBSTETRICIAN/GYNECOLOGIST (OB/GYN) CARE

ATTENTION FEMALE MEMBERS: Your HMO plan provides direct access to participating OB/GYNs for gynecologic and obstetric conditions, including annual well-woman exams and maternity care, without first obtaining a referral from a PCP or calling HMO. Your PCP, or participating OB/GYN,will establish a referral for you for any required obstetric/gynecologic specialty care.

You must go to an OB/GYN who is within the same provider network as your PCP.It is not required that you select an OB/GYN; you may choose to receive your OB/GYN services from your PCP.

If you need help in locating a participating OB/GYN in your area, please refer to the online provider directory (an Internet-based provider directory available on our website at https://www.bcbstx.com/find-a-doctor- or-hospital), or to your provider directory, or call Customer Service at the toll-free telephone number on the back of your ID card for assistance.

SERVICE AREA

For a map of the HMO service area, please refer to the website at https://www.bcbstx.com/find-a-doctor-or- hospital for Provider Finder, an Internet-based provider directory, or request a hard copy or electronic copy of the provider directory by calling Customer Service.

GENERAL INFORMATION

Identification (ID) Card

Once enrolled, you and each of your covered dependents will receive an ID card. Please take a moment to check the following information on the card for accuracy, and call Customer Service if changes are needed.

- Identification number
- Coverage effective date
- Your and/or your covered dependents' names
- Group number
- Primary care physician/practitioner (or "PCP") name
- PCP telephone number

Your ID card also shows certain copayments and any other amounts due for services that are part of the plan selected.

The back of your ID card includes the toll-free Customer Service telephone number.

Be sure to take your ID card with you when you seek health care. It has important information on it that your PCP or other health care professional will need to know. Always present your ID card to the medical office staff, so they can verify eligibility and collect the appropriate copayment and any other amounts due.

If your ID card is lost or stolen, please call Customer Service immediately and a new ID card will be sent to you. Or you may go to the website at www.bcbstx.com and print a temporary ID card or order a replacement under the Blue Access for Members section. You will also receive an updated ID card if you change your PCP, or if your PCP changes to another network.

REMEMBER:

- Your COC contains important details about your health care benefits. Please review them carefully. Please contact Customer Service if you have questions about your plan.
- Your provider directory gives you a complete listing of participating providers in your area. Please contact Customer Service if you need assistance in locating a PCP in your area.
- Take your ID card with you when you seek care. It has important information your provider needs to know.

RECEIVING CARE

Your Primary Care Physician/Practitioner (PCP)

We encourage you to make an appointment with your PCP before you need health care so that you can establish yourself as a patient. One of the advantages of establishing a physician/patient relationship with your PCP is that your PCP becomes familiar with you and your medical history, which helps make sure you receive the care that is right for you.

It is very important to visit or contact your PCP first when seeking medical care. Your PCP will either treat you or refer you for specialty care. Your PCP will also coordinate any required hospital admissions.

REMEMBER:
Always see your PCP first when you need health care. Services received from any provider without a referral from your PCP will not be covered, except in emergency situations or for OB/GYN services provided by a participating OB/GYN in your network, as described below.

Changing PCPs

Changing your PCP is easy. Simply use the online provider directory at www.bcbstx.com, refer to your provider directory, or call Customer Service for assistance in selecting a new PCP in your area. Sometimes a PCP may not be accepting new patients. When selecting a new PCP, you may call Customer Service or the PCP's office and ask about availability. If the PCP is unavailable, Provider Finder or Customer Service can help you find another physician in your area.

Once you've made your decision, either call Customer Service, or complete a change form and submit it to: Membership Department, P.O. Box 655730, Dallas, Texas 75265-5730. You may also request the transfer of your medical records from your previous PCP to the newly selected physician.

PCP changes become effective the first day of the month following the HMO's receipt and approval of your request. You will receive an updated ID card that shows your new PCP's name and telephone number. If you need health care but have not received your new ID card with your new PCP's name, please call Customer Service to verify that your request has been processed. You may also go to the website at www.bcbstx.com and print a temporary ID card under the Blue Access for Members section.

Making Appointments

You may make appointments for periodic health assessments at a time convenient for you.

If the nature of an illness warrants an urgent appointment, your PCP can generally fit you into his or her schedule within a reasonable period of time. If your PCP cannot fit you in, he or she may direct you to a designated back-up physician. If you need assistance, you may call Customer Service at the telephone number on the back of your ID card.

If you need to change or cancel an appointment, be sure to call your PCP as soon as you can. When you visit your PCP's office for covered services, you will pay only a copayment and any other applicable coinsurance or deductibles for the office visit. There are no claims to file. If you need the care of a specialist, your PCP will refer you and will handle any Prior Authorization requirements for you.

REMEMBER:

- Have your health care provided or arranged by your PCP.
- For obstetric or gynecologic conditions, you may directly access a participating OB/GYN (in the same provider network as your PCP).
- Contact Customer Service for assistance in changing your PCP.
- It is important to schedule an appointment with your PCP as soon as you can. Contact Customer Service if your PCP cannot fit you in.

ADDITIONAL INFORMATION

Status Changes

Your records are very important to us. Incorrect records can delay membership verification or medical care, create problems in continuing coverage for a dependent, and possibly cost you money. To keep your coverage up to date, see your employer for specific instructions about submitting forms to notify us of any changes. Completed forms must be received by the HMO within 31 days from the date of any change listed below:

- Birth of a child;
- Adoption or becoming a party in a suit for adoption, or legal guardianship;
- Change of dependency status of a child;
- Court-ordered dependents;
- Loss of other health coverage;
- Marriage;
- Divorce;
- Death;
- Change of address; and
- Change of telephone number.

Coverage will be automatic for a subscriber or a subscriber's spouse's newborn child for the first thirty-one (31) days following the date of birth. Coverage will continue beyond the thirty-one (31) days only if the child is an eligible dependent and You notify the HMO (verbally or in writing), or submit an enrollment application/change form to the HMO timely and make, or agree to make, any additional premium payments.

Duplication of Coverage and Coordination of Benefits

If you or your dependents are covered by more than one health benefit plan, you may have duplicate coverage. Each covered dependent will then have "primary" and "secondary" coverage. At the time of enrollment, you were asked to provide information about your other health benefit plan. Please notify Customer Service of any change in your duplicate coverage.

Injuries and sometimes illnesses may be covered by other types of insurance such as auto, homeowners or workers' compensation. Please call Customer Service in cases such as these for information on what steps to take.

It is important that you provide this information to us to allow coordination of payment of your claims to ensure that claims are not paid twice. This helps keep your health care costs down.

Continuation of Benefits

Under the Consolidated Omnibus Budget Reconciliation Act (federal legislation called COBRA), many employers offer a continuation of group coverage if you become ineligible for group membership. Ask your employer if this coverage is available to you. You may also be able to continue your coverage under State Continuation guidelines, as explained in your COC.

REMEMBER:

- Notify us within 31 days of a change to your eligibility.
- Be sure to indicate any other health coverage you have or contact Customer Service with this information.
- You may be eligible to continue your membership. Please review the guidelines above to see if you are eligible.

New Medical Technology

The HMO keeps abreast of medical breakthroughs, experimental treatments, and newly approved medication. The medical policy department evaluates new technologies, medical procedures, drugs, and devices for potential inclusion in the benefit packages we offer. Clinical literature and accepted medical practice standards are assessed thoroughly with ongoing reviews and determinations made by our Medical Policy Group.

YOUR RIGHTS AND RESPONSIBILITIES

You have certain rights and responsibilities when receiving health care services and should expect the best possible care available. We have provided the following information, so you can be an informed customer and active participant in your plan.

Your Rights
You have the right to:

- Select or change your PCP and know the qualifications, titles, and responsibilities of the professionals responsible for your health care;
- Receive prompt and appropriate treatment for physical or emotional disorders and participate with your providers in decisions regarding your care;
- Be treated with dignity, compassion, and respect for your privacy;
- Have a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage;
- Have all medical and other information held confidential unless disclosure is required by law or authorized in writing by you;
- Be provided with information about:
    - The HMO;
    - Health care benefits;
    - Copayments, copayment limitations, and/or other charges;
    - Service access;
    - Changes and/or termination in benefits and participating providers;
    - Exclusions and limitations;
- Express opinions, concerns, and complaints in a constructive manner or appeal regarding any aspect of the HMO;
- Receive timely resolution of complaints or appeals through Customer Service and the complaint procedure;
- Have access to review by an Independent Review Organization;

- Refuse treatment and be informed of the medical consequences that may be a result of your decision; and
- Make recommendations regarding your HMO rights and responsibilities policies.

Your Responsibilities
You have the responsibility to:

- Meet all eligibility requirements;
- Identify yourself by presenting your ID card and pay the copayment and any other applicable amount due at the time of service for network benefits;
- Establish a physician/patient relationship with your PCP and seek your PCP's medical advice/referral for network services prior to receiving medical care, unless it is an emergency situation or services are performed by your HMO participating OB/GYN;
- Understand the medications you are taking and receive proper instructions on how to take them;
- Communicate complete and accurate medical information to health care providers;
- Call in advance to schedule appointments with network providers and notify them prior to canceling or rescheduling appointments;
- Ask questions, follow instructions, and guidelines given by providers to achieve and maintain good health;
- Discuss disagreements and/or misunderstandings regarding treatment from providers;
- Notify your PCP or the HMO within 48 hours or as soon as reasonably possible after receiving emergency care services;
- Provide, to the extent possible, information that the HMO needs in order to administer your benefit plan, including changes in your family status, address and telephone numbers;
- Read your COC for information about the HMO benefits, limitations, and exclusions; and
- Understand your health conditions and participate to the degree possible in the development of treatment goals mutually agreed upon between you and your provider.

CONFIDENTIALITY AND ACCESS TO RECORDS

We are required by federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services. With limited exceptions, your medical records may not be disclosed to others, including your employer, without your written consent. You, or an individual acting on your behalf, may request medical records for the purpose of providing care or resolving disputes related to coverage, reimbursement, or complaints.

Routine consent signed at the time of enrollment permits us to release information for purposes of quality assessment and measurement, treatment, coordination of care, accreditation, billing, and other uses. Identifiable information is minimized and protected from inappropriate disclosure. Information provided to employer groups is aggregated to protect the identification of any individual.

You have a right to specifically approve the release of information beyond the uses identified in the routine consent that you sign upon enrollment and, at other times, as needed for worker's compensation claims, auto insurance claims, marketing, or data used for research studies.

You may give us written authorization to use your PHI, or to disclose it, to another person only for the purpose you designate. PHI may not be disclosed to your spouse or family without written authorization from you or an authorized representative. Information regarding children under 18 years of age may be released to a parent or legal guardian. If an adult is incapacitated, a legally appointed guardian may act on their behalf. Unless you give us written authorization, we cannot use or disclose your PHI for any reason except those described in the HIPAA Notice.

Participating providers must comply with applicable HIPAA laws, professional standards, and policies regarding the confidential treatment of medical information, including security measures to control access to confidential information maintained in computer systems. Access to electronic files containing information is to be protected and restricted to employees who have a business-related need to know. Oral, written, and electronic personal health information across the organization will be kept confidential in accordance with applicable law.

Blue Cross Blue Shield of Texas understands the importance of confidentiality and respects your right to privacy. A summary of our privacy practices is available on the BCBSTX website at www.bcbstx.com/privacy.htm, or you may call Customer Service at the telephone number on the back of your ID card to obtain a paper copy.

CUSTOMER SERVICE

Questions

If you have questions about your benefits, Customer Service representatives are available to help you at the telephone number on the back of your ID card. Customer Service can also help if you want to change your PCP. They will have an up-to-date list of participating providers in your area.

Customer Service can also assist you with special communications needs. If your first language is not English, you can ask to speak to a bilingual staff member (English or Spanish). Some written materials (including this Plan Description and Member Handbook) are available in Spanish. Members may also ask for access to a telephone-based translation service to assist with other languages.

BCBSTX provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing, and speech-disabled members. Members can utilize their TeleTypewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator.

If you are not satisfied with service you have received, the HMO has a formal complaint process you can follow to advise us of issues related to quality of care or service. We monitor the care you receive and follow through on all complaints and inquiries, because your satisfaction is important to us.

NOTICE

OUT-OF-NETWORK PHYSICIANS AND PROVIDERS

This notice is to advise you of your rights regarding services from out- of- network physicians and providers. Out- of- network physicians and providers are not part of the HMO's network of participating providers.

A health maintenance organization (HMO) plan does not provide benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Certificate of Coverage and below.

- You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers*).
- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out- of- network services because no network physician or provider is available, or if you have received out- of- network emergency care, the HMO must, in most cases, resolve the out- of- network physician's or provider's bill so that you only have to pay any applicable in- network copayment, coinsurance, and deductible amounts.
- You may obtain a current directory of network physicians and providers at the following website: https://www.bcbstx.com/find-a- doctor-or-hospital or by calling 1-877-299-2377 for assistance in finding available network physicians and providers. If you relied upon materially inaccurate directory information, you may be entitled to have a claim by an out- of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

AMENDMENTS

AMENDMENT

This Amendment is to advise you of a change to your Certificate of Coverage with Blue Cross and Blue shield of Texas, a Division of Health Care Service Corporation.
This Amendment is issued to and made a part of your Certificate of Coverage (the Plan) to which it is attached.

The section entitled **Have a complaint or need help?** Is hereby amended as follows:
The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

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

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

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

This is an amendment to your Certificate of Coverage and the Plan Description and Member Handbook. It is to be attached to and becomes part of the Certificate of Coverage and Plan Description and Member Handbook. This amendment may be delivered to you electronically, but a paper copy of this amendment is available on request.
The section entitled **COMPLAINT AND APPEAL PROCEDURES** is hereby amended as follows:
How to Appeal to the Texas Department of Insurance
Anyone, including persons who attempted to resolve Complaints through HMO's Complaint process and are dissatisfied with the resolution, may report an alleged violation to Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

The **Plan Description and Member Handbook** is hereby amended as follows:
Filing Complaints with the Texas Department of Insurance
Any person, including those who have attempted to resolve complaints through HMO's complaint process, who is dissatisfied with the resolution, may report their dissatisfaction to Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

AMENDMENT

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Certificate of Coverage to which this amendment is attached will remain in full force and effect.

By: President, Blue Cross and Blue Shield of Texas

BLUE CROSS AND BLUE SHIELD OF TEXAS
A DIVISION OF HEALTH CARE SERVICE CORPORATION
(herein called "BCBSTX" or "HMO")

This is an Amendment to your Plan Description and Member Handbook. It is to be attached to, and becomes part of, the Plan Description and Member Handbook. This amendment may be delivered to you electronically, but a paper copy of this Amendment is available on request.

The **Plan Description and Member Handbook, Network Providers section** is amended to add the following information:

The following demographics describe the network as of September 2020, that your Texas HMO Plan provides access to for the provision of Covered Services.

Network	Enrollees	Specialty	Participating Providers	Access
Blue Essentials Network	51,958	Internal Medicine	9,575	Yes
		Family/Gen. Practice	12,683	Yes
		Pediatrics	5,348	Yes
		Obstetrics and Gynecology	3,262	Yes
		Anesthesiology	4,474	Yes
		Psychiatry	1,358	Yes
		General Surgery	1,895	Yes
		Acute Care Hospitals	507	Yes

For additional information regarding network adequacy, please call the customer service toll-free telephone number shown on the back of your Identification Card or visit the website at https://www.bcbstx.com.

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage. Except as changed by this Amendment, all terms, conditions, limitations, and exclusions of the Member Handbook and Plan Description to which this Amendment is attached, will remain in full force and effect.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: James Springfield
President, Blue Cross and Blue Shield of Texas

BlueCross BlueShield of Texas

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