

**BLUE CROSS AND BLUE SHIELD OF TEXAS
A DIVISION OF HEALTH CARE SERVICE
CORPORATION
(herein called “BCBSTX” or “HMO”)**

**1001 East Lookout Drive
Richardson, Texas 75082
1-888-697-0683**

EVIDENCE OF COVERAGE

NOTICE TO CONSUMER

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation (“HMO”) agrees to provide You coverage for benefits in accordance with the conditions, rights, and privileges set forth in this Evidence of Coverage. The Evidence of Coverage determines the terms and conditions of coverage. Provisions of this Evidence of Coverage include the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any amendments, or attachments, which may be delivered with the Evidence of Coverage or added later. This Evidence of Coverage is currently certified by the Exchange as a Qualified Health Plan.

Notice of Ten-Day Right To Examine. Within ten days after its delivery to You, this Evidence of Coverage may be surrendered by returning it to HMO at our administrative office, agent, or the entity through whom it was purchased. Upon such surrender, any Premiums paid will be returned. Subscriber is responsible for repaying HMO for any services rendered or claims paid by HMO on behalf of the Subscriber, or any Dependents, during the ten day examination period.

IN CONSIDERATION of the payment of Premiums in accordance with the provisions hereof, this Evidence of Coverage describes 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 in **GENERAL PROVISIONS**, coverage is not provided for any services received before coverage starts or after coverage ends.

Certain words have specific meanings in this Evidence of Coverage. Defined terms are capitalized and shown in the appropriate provision or in the **DEFINITIONS** section and in the amendments or attachments to this Evidence of Coverage, if applicable. Hereinafter, we refer to the Health Insurance Marketplace as “Exchange”.

This Evidence of Coverage is not a workers’ compensation insurance policy. Ask Your employer if they subscribe to the workers’ compensation system. This Evidence of Coverage 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.

Please read this entire Evidence of Coverage carefully, as it describes Your rights and obligations and those of the HMO. It is Your responsibility to understand these terms and conditions, because in some circumstances, certain medical services are not covered or may require Preauthorization by HMO.

No services are covered by this Evidence of Coverage if current Premiums have not been paid. If the Evidence of Coverage is terminated for nonpayment of Premium, You are responsible for the cost of services received during the grace period described in **HOW THE PLAN WORKS**.

This Evidence of Coverage 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 HMO.

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

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call HMO's toll-free telephone number for information or to make a complaint at:

1-888-697-0683

You may also write to HMO at:

Blue Cross and Blue Shield of Texas,
a Division of Health Care Service Corporation
P.O. Box 660044
Dallas, Texas 75266-0044

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

1-800-252-3439

You may write the Texas Department of Insurance at:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 490-1007
Web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

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

AVISO IMPORTANTE

Para obtener información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de HMO's para obtener información o para presentar una queja al:

1-888-697-0683

Usted también puede escribir a HMO:

Blue Cross and Blue Shield of Texas,
a Division of Health Care Service Corporation
P.O. Box 660044
Dallas, Texas 75266-0044

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P. O. Box 149104
Austin, Texas 78714-9104
Fax: (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

ADJUNTE ESTE AVISO A SU PÓLIZA: Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

NOTICE OF SPECIAL TOLL-FREE COMPLAINT NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELFONICOGRATIS ESPECIAL PARA QUEJAS

PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-832-9623

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

Sample

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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 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.

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.

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 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**.

DEFINITIONS

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, pre-eclampsia, 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 Evidence of Coverage 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**.

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 twenty-four (24) 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.

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 **PHARMACY BENEFITS**.

Dependent(s) means the Subscriber's spouse or child who has been determined eligible to enroll through the Exchange in a Qualified Health Plan (QHP).

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 and who has been determined eligible for coverage by the Exchange.

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 Evidence of Coverage as shown on the records of HMO.

DEFINITIONS

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 to 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.

Exchange (also known as health insurance marketplace) means a governmental agency or non-profit entity that meets the applicable Exchange standards, and other related standards established under applicable law, and makes Qualified Health Plans (QHPs) available to Qualified Individuals and qualified employers (as these terms are defined by applicable law). Unless otherwise identified, the term Exchange refers to the State Exchanges, regional Exchanges, subsidiary Exchanges, a Federally-facilitated Exchange or other Exchange on which Blue Cross and Blue Shield of Texas offers this QHP.

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. 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.

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

Although a 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.

Habilitation Services means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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.

DEFINITIONS

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 HMO to render Hospice care to Members.

Hospital means an acute care institution which:

- 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 twenty-four (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 Evidence of Coverage) 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.

Limited Provider Network means a subnetwork within an HMO delivery network in which contractual relationships exist between Physicians, certain Providers, independent Physician associations and/or Physician groups which limit Your access to only the Physicians and Providers in the subnetwork.

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

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

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

- social and emotional factors related to Member's illness, need for care, response to treatment and adjustment to care; and
- relationship of Member's medical and nursing requirements to the home situation, financial resources, and available community resources.

DEFINITIONS

Medically Necessary 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; and
- the most economical supplies or levels of service appropriate for Your safe and effective treatment.

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, 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 Evidence of Coverage.

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

Member means a Subscriber or Dependent(s) covered under this HMO Evidence of Coverage. This Evidence of Coverage 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 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 infirmity 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.

Minimum Essential Coverage means health insurance coverage that is recognized as coverage that meets substantially all requirements under federal law pertaining to adequate individual, group or government health insurance coverage. For additional information on whether particular coverage is recognized as "Minimum Essential Coverage", please call the customer service telephone number shown on the back of Your identification card or visit www.cms.gov.

DEFINITIONS

Obstetrician/Gynecologist means a Participating Physician contracted by 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.

Open Enrollment Period means the period each year during which a Qualified Individual may enroll or change coverage in a Qualified Health Plan (QHP) through the Exchange.

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

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

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.

Preauthorization means a determination by HMO that health care services proposed to be provided to a patient are Medically Necessary and appropriate. Preauthorization processes will be conducted in accordance with Texas Insurance Code, chapter 4201, or in accordance with the laws in the state of Texas.

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

Premium Tax Credit means a refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, 2013, to the extent provided under applicable law, where the credit is meant to offset all or a portion of the Premium paid by the individual for coverage obtained through an Exchange during the preceding Calendar Year.

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 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.

Professional Services means those Medically Necessary Covered Services rendered by Physicians and other Health Care Professionals in accordance with this Evidence of Coverage. 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.

DEFINITIONS

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.

Qualified Health Plan (QHP) means a health care benefit program that has in effect a certification that it meets the applicable government standards, issued or recognized by each Exchange through which such program is offered.

Qualified Health Plan Issuer or QHP Issuer means a health plan issuer that offers a QHP in accordance with a certification from an Exchange.

Qualified Individual(s) means, an individual who has been determined eligible to enroll through the Exchange in a Qualified Health Plan (QHP).

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 HMO's policies and procedures that direct You to a Participating Provider for Medically Necessary care.

Rehabilitation Services means health care services, including devices, provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

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. 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 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 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 .

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.

DEFINITIONS

Routine patient care costs do not include:

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

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

- schizophrenia;
- paranoid 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 HMO and approved by state regulatory authorities. The applicable Service Area includes the area shown and described in **SERVICE AREA**.

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 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 Evidence of Coverage, and whose enrollment application and Premium payment have been received by HMO.

Telehealth Services means a health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional Provider acting within the scope of the Health Care Professional Provider's license or certification who does not perform a Telemedicine Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- compressed digital interactive video, audio, or data transmission;
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Services means a health care service initiated by a Physician or provided by a health professional Provider acting under Physician delegation and supervision for purposes of patient assessment by a health professional, diagnosis, or consultation by a Physician, treatment or the transfer of medical data that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- compressed digital interactive video, audio or data transmission;
- clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- other technology that facilitates access to health care services or medical specialty expertise.

DEFINITIONS

Tobacco User means a person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of tobacco), occurring on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, etc. For additional information, please call customer service at the toll-free number on the back of Your identification card or visit the website at www.bcbstx.com.

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 facility, 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 HMO for the provision of Covered Services for Urgent Care to Members.

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

Virtual Visits means services provided for the treatment of non-emergency medical and behavioral health conditions as described in **COVERED SERVICES AND BENEFITS**.

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

Sample

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 Evidence of Coverage is provided regardless of your race, color, national origin, disability age, sex gender identity or sexual orientation. Variations in the administration, processes or benefits of this Evidence of Coverage 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.

Eligibility for this coverage will be determined by the Exchange in accordance with applicable law. For questions regarding eligibility, refer to healthcare.gov.

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

1. reside, live or work in the Service Area; and
2. have been determined eligible to enroll through the Exchange.

Dependent Eligibility. To be eligible to enroll as a Dependent, a person must meet all eligibility requirements as determined by the Exchange and:

1. reside in the Service Area or permanently reside with a Subscriber who works in the Service Area, except as provided in **item 5**, below; and
2. be Subscriber's spouse or Domestic Partner. Subscriber may be required to submit a certified copy of a marriage license or declaration of informal marriage with Dependent's enrollment application before coverage will be extended; or
3. be a Dependent child, which hereafter means a natural child, eligible foster child, a stepchild, an adopted child (including a child for whom the Subscriber or Subscriber's spouse is a party in a suit 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, enrolled in or eligibility for other coverage or any combination of those 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.

In addition, a Dependent shall include a child for whom Subscriber or Subscriber's spouse is a court-appointed legal guardian, provided proof of such guardianship is submitted with the prospective Dependent's enrollment application; or

4. be a child of any age, as defined in **item 3** 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. Subscriber must provide HMO with a Dependent Child's Statement of Disability form, including a medical certification of disability, and subsequently as may be required by HMO, but not more often than once per year. HMO's determination of eligibility shall be conclusive; or
5. have a court order for coverage to be provided for a spouse or minor child under Subscriber's Health Benefit Plan and application shall be made within sixty (60) days after issuance of the court order.

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

Loss of Eligibility. You must notify HMO and the Exchange of any changes that will affect Your eligibility, or that of Your Dependents, for services or benefits under this Evidence of Coverage within sixty (60) days of the change.

WHO GETS BENEFITS

Enrollment

Annual Open Enrollment Periods/Effective Date of Coverage. Annual Open Enrollment Periods have been designated during which You may apply for or change coverage for yourself and/or Your eligible dependents. When You enroll during the annual Open Enrollment Period Your and/or Your eligible Dependents' effective date will be the following January 1, unless otherwise designated by the Exchange and HMO, as appropriate.

Coverage under this Evidence of Coverage is contingent upon timely receipt by HMO of necessary information and initial Premium.

This section **Annual Open Enrollment Periods/Effective Date of Coverage** is subject to change by the Exchange, HMO, and/or applicable law, as appropriate.

Newborn Children Coverage. Coverage will be automatic for Subscriber or 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 verbally notify HMO or submit an enrollment application within thirty-one (31) days and make or agree to make any additional Premium payments in accordance with this Evidence of Coverage. Note: Application must be made to the Exchange within 30 days and You make or agree to make any additional Premium payments in accordance with this Evidence of Coverage. The Effective Date of Coverage for newborn children shall be the newborn's date of birth.

Late Enrollees

Special Enrollment Periods/Effective Dates of Coverage

Special enrollment periods have been designated during which You may apply for or change coverage in a QHP through the Exchange for yourself and/or Your eligible Dependents. You must apply for or request a change in coverage within 60 days from the date of a special enrollment event in order to qualify for the changes described in the **Special Enrollment Periods/Effective Dates of Coverage** section.

Except as otherwise provided below, if You apply between the first day and 15th day of the month, Your effective date will be no later than the first day of the following month, or if You apply between the 16th day and the end of the month, Your and Your eligible Dependents' effective date will be no later than the first day of the second following month.

Special Enrollment Events:

1. You and/or Your eligible Dependents experience a loss of Minimum Essential Coverage. New coverage for You and/or eligible Dependents will be effective no later than the first day of the month following the loss.

A loss of Minimum Essential Coverage does not include failure to pay Premiums on a timely basis, including COBRA Premiums prior to the expiration of COBRA coverage, or situations allowing for a Rescission, as determined by the Exchange and HMO, as appropriate.

2. You and/or Your eligible Dependents gain a Dependent or become a Dependent through marriage. New coverage for You and/or Your eligible Dependents' will be effective no later than the first day of the following month.
3. You and/or Your eligible Dependents gain a dependent through birth, adoption (including a suit for adoption), or placement for adoption or court-ordered dependent Coverage. New coverage for You and/or Your eligible Dependents will be effective on the date of the birth, adoption, foster care placement for adoption or the date the Subscriber becomes a party to a suit in which the Subscriber seeks to adopt a child. However, advance payments of any Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month. The effective date for court-ordered eligible child coverage will be determined by HMO in accordance with the provisions of the court order.

WHO GETS BENEFITS

4. You and/or Your eligible Dependents were not previously a U.S. citizen(s), national(s), or lawfully present in the U.S. and gain such status.
5. Your and/or Your eligible Dependents enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous as evaluated and determined by the Exchange and/or HMO, as appropriate.
6. You and/or Your eligible Dependents adequately demonstrate to the Exchange that the QHP in which You are enrolled substantially violated a material provision of its contract in relation to You.
7. You and/or Your eligible Dependents are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or have a change in eligibility for cost-sharing reductions, regardless of whether You are already enrolled in a QHP.
8. You and/or Your eligible Dependents gain access to new QHPs as a result of a permanent move.
9. You and/or Your eligible Dependents are an Indian, as defined by section 4 of the Indian Health Care Improvement Act. You may enroll yourself and/or Your eligible Dependents' in a QHP or change from one QHP to another one time per month.
10. You and/or Your eligible Dependents demonstrate to the Exchange, in accordance with the guidelines, that You meet other exceptional circumstances as the Exchange may provide.

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate Premiums in accordance with the guidelines as established by the Exchange and HMO, as appropriate.

Removing a Dependent From Coverage

To remove a Dependent from coverage, the Subscriber must submit a request to HMO and the Exchange, as appropriate. You may re-enroll these terminated individuals under the Evidence of Coverage only during the Open Enrollment Period or special enrollment period. If an individual is being removed from coverage because of losing his/her eligibility under the Evidence of Coverage, the individual is eligible to enroll under the Evidence of Coverage only during the Open Enrollment Period or special enrollment period, as applicable, by submitting application(s) to the Exchange and HMO, as applicable.

Child-Only Coverage

Eligible children that have not attained age 21 may enroll as the Subscriber under this Evidence of Coverage (health care plan). In such event, this Evidence of Coverage is considered child-only coverage and the following restrictions apply:

- The parent or legal guardian is not covered and is not eligible for benefits under this health care plan.
- If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to HMO and the Exchange, as appropriate. For any child under 18 covered under this Evidence of Coverage, any obligations set forth in this Evidence of Coverage, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for a child-only coverage will not be accepted for an adult child that has attained age 21 as of the beginning of the plan year. Adult children (at least 18 years of age but no older than 20 years of age) who are applying for coverage as a Subscriber under this Evidence of Coverage must sign or authorize the applications(s).

HOW THE PLAN WORKS

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**. Some Covered Services may also require Preauthorization by HMO. Preauthorization processes will be conducted in accordance with Texas Insurance Code, chapter 4201, or in accordance with the laws in the state of Texas.

Only services that are performed, prescribed, directed or authorized in advance by the PCP or HMO are covered benefits under this Evidence of Coverage except Emergency Care, Urgent Care, Virtual Visits, Retail Health Clinic visits 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.

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. You may also request a written copy of the Participating Provider directory, which is updated quarterly, by calling customer service. Each directory identifies those Providers who are accepting existing patients only. 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.

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 Evidence of Coverage, 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.

HOW THE PLAN WORKS

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

- A. If You are under the care of a Participating Provider who stops participating in HMO's network, HMO will continue coverage for that Provider's Covered Services if all the following conditions are met:
- You have a disability, acute condition, life-threatening illness or are past the thirteenth (13th) week of pregnancy; and
 - the Provider submits a written request to HMO to continue coverage of Your care that identifies the condition for which You are being treated and 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 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.

- B. In addition, if You are under the care of a Participating Provider who stops participating in HMO's network (for reasons other than misconduct, breach of contract, loss of license or other similar reason), You may be able to continue coverage for that Provider's Covered Services for the following:
- An ongoing course of treatment for a serious acute disease or condition requiring complex ongoing care that You are currently receiving (for example, You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition);
 - An ongoing course of treatment for a life-threatening disease or condition and the likelihood of death is probable unless the course of the disease or condition is interrupted;
 - An ongoing course of treatment for the second and third trimester of pregnancy through the postpartum period; or
 - An ongoing course of treatment for a health condition for which a treating Provider attests that discontinuing care by the Participating Provider who is terminating from the network would worsen the condition or interfere with anticipated outcomes.

Continuity coverage described in this subsection B shall continue until the treatment is complete (or postpartum) but will not extend for more than ninety (90) days beyond the date the Provider's termination takes effect.

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

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**.

HOW THE PLAN WORKS

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 Deductible. You are responsible only for the Copayments/Coinsurance and any Deductible 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.

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 an application or other forms or statements that may be reasonably requested. You agree that all information contained in the applications, forms and statements submitted to HMO and the Exchange due to enrollment under this Evidence of Coverage 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.

HOW THE PLAN WORKS

- You understand that HMO and the Exchange are acting in reliance upon all information You provided at time of enrollment and afterwards and represents that information so provided is true and accurate.
- By electing coverage pursuant to this Evidence of Coverage, 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, You shall remit payment on behalf of each Subscriber and Dependents the amount specified by HMO.

A Tobacco User may be subject to a Premium increase of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law.

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 for You and/or your Dependents or there is a bank draft failure, then You will be terminated at the end of the grace period. 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 You.

Policy on third-party payment of Cost-Sharing and Premium. HMO only accepts cost-sharing and Premium payments from (1) the Member; (2) the Member's family; (3) Required Entities (the entities the law requires HMO to accept cost-sharing payments from, which as of the Effective Date currently are Ryan White HIV/AIDS programs, under title XXVI of the Public Health Service Act, Indian tribes, tribal organizations and urban Indian organizations; and State and Federal government programs, as described in 45 C.F.R. § 156.1250); and (4) private non-profit foundations that make cost-sharing assistance available to the Member: (a) for the entire coverage period of the Member's Policy, (b) based solely on financial criteria (c) regardless of the Member's health status, and (d) regardless of which insurance issuer and/or benefit plan the applicant chooses. Cost-sharing payments from any other party, other than those listed above, will not be applied to Your coverage. Premium payments from any party, other than those listed above, will not be credited to Your account which may result in termination or cancellation of coverage in accordance with the Termination provisions of this Evidence of Coverage.

A grace period of 31 days, or such other grace period, if any, permitted by applicable law or regulatory guidance, will be granted for the payment of each Premium falling due after the first Premium, during which grace period, the Evidence of Coverage shall continue in force. After a grace period of 31 days, coverage under this Evidence of Coverage will automatically terminate on the last day of the coverage period for which Premiums have been paid, unless coverage is extended as described in the next paragraph.

In the event you are receiving a Premium Tax Credit under the Affordable Care Act, You have a three-month grace period, or such other time period as required or permitted by applicable law, regulation or guidance, for paying Premiums. If full Premium is not paid within one month of the premium due date, Claim payments for Covered Services received during the second and third calendar months of the grace period under this Evidence of Coverage will be pended until full premium payment is made.

HOW THE PLAN WORKS

If full payment of the Premium is not made within the three months grace period, then coverage under this Plan will automatically terminate on the last day of the first month of the three-month grace period. HMO will not process any claims for services after the date of termination.

During the grace period in the event You are receiving a Premium Tax Credit, HMO will:

- Pay all appropriate claims for services rendered during the first month of the grace period and may pend claims for services rendered in the second and third months of the grace period;
- Notify the Department of Health and Human Services of such non-payment; and,
- Notify Providers of the possibility of denied claims during the second and third months of Your grace period.

HMO reserves the right to change the schedule of Premium payments on each anniversary date of this Evidence of Coverage upon 60 days written notice.

The Affordable Care Act (ACA) requires that covered entities providing health insurance (“health insurer”) pay an annual fee to the federal government (the “Health Insurer Fee”). The amount of this fee for a calendar year will be determined by the federal government and currently involves a formula based in part on a health insurer’s net premiums from the preceding calendar year. In addition, ACA and/or other applicable laws may provide for the establishment of temporary transitional reinsurance program(s) that may be funded by reinsurance contributions or other amounts (collectively, the “Reinsurance Fees or Amounts”) from health insurance issuers and/or self-funded group health plans. Federal and/or state governments may provide information as to how the Reinsurance Fees or Amounts are calculated. Your Premium will be adjusted to reflect the effects of the Health Insurer Fees and the Reinsurance Fees or Amounts, if any.

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 APPEALS PROCEDURES**. Complaints may concern non-medical or medical aspects of care as well as this Evidence of Coverage, including its breach or termination.

Identification Card

Cards issued to Members under this Evidence of Coverage are for identification only. The identification card confers no right to services or other benefits under this Evidence of Coverage. 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 Evidence of Coverage 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 as Your insurer.
- Any Copayment Amounts that may apply to Your coverage.
- Important telephone numbers.

Always remember to carry Your identification card with You and present it to Your Providers or 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;

HOW THE PLAN WORKS

- b. Use of the identification Card after Your date of termination of coverage under the Evidence of Coverage;
 - c. Obtaining prescription drugs or other benefits for persons not covered under the Evidence of Coverage;
 - d. Obtaining prescription drugs or other benefits that are not covered under the Evidence of Coverage;
 - 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 Evidence of Coverage;
 - 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 Evidence of Coverage;
 - 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 Evidence of Coverage 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 applicable 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 to obtain a medical claim form or a prescription reimbursement claim form.

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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 APPEALS PROCEDURES**.

Service Area

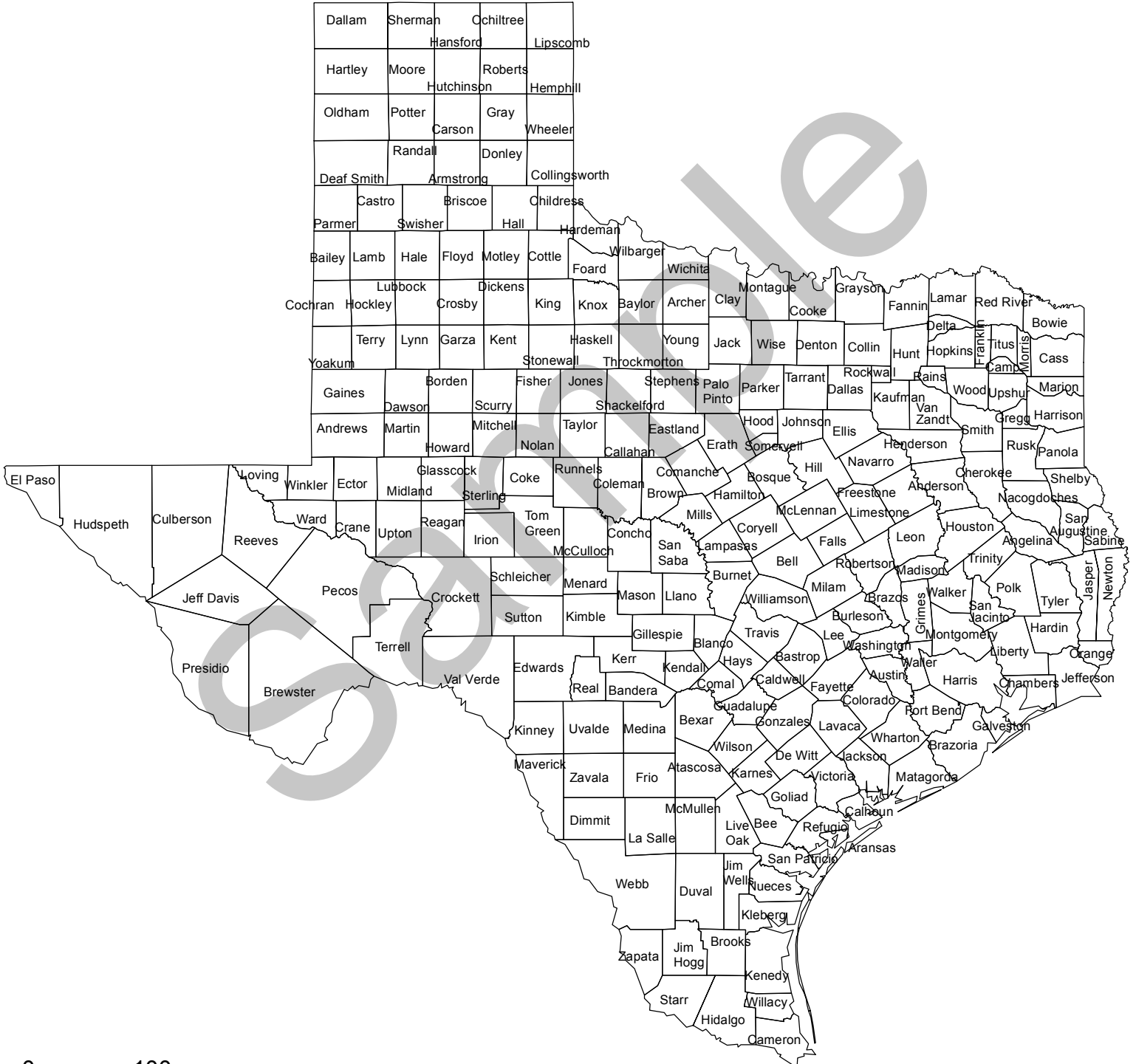
See Service Area map and description on the following page(s).

Sample

SERVICE AREA

Service Area

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



SERVICE AREA

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

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;
- 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**.

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, including termination or refusal to renew this Evidence of Coverage, because You have 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.

COMPLAINT AND APPEAL PROCEDURES

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).

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.

COMPLAINT AND APPEAL PROCEDURES

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 or fax to (512) 490-1007.

You may file a TDI Complaint:

- by mailing to the address listed above;
- by faxing to the number 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. 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 this Evidence of Coverage, 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 Evidence of Coverage, You will be notified no later than the 30th day before the date on which coverage will be discontinued.

COMPLAINT AND APPEAL PROCEDURES

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 this Evidence of Coverage 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. 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 this Evidence of Coverage, 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.

- 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 this Evidence of Coverage, 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.

For more information about the IRO process, call TDI on the IRO information line at (866) 554-4926, or in Austin call (512) 322-4266.

COVERED SERVICES AND BENEFITS

Copayments/Coinsurance

You are liable for certain Copayments/Coinsurance and any applicable 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 in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Deductibles

Benefits are available under this Evidence of Coverage after satisfaction of any applicable Deductibles shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

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 in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. When the family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year.

Out-of-Pocket Maximums

HMO will determine when maximums have been reached for Covered Services based on information provided to HMO by You and Participating Providers to whom You have made payments for Covered Services. Out-of-pocket maximums will include Copayments, Coinsurance and Deductibles. Once You reach the out-of-pocket maximum, You are not required to make additional payments for Covered Services 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 in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. When the family out-of-pocket maximum amount is reached, You are not required to make additional payments for Covered Services 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 Copayment/Coinsurance and any other amounts due shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**;
- may have limitations, restrictions or exclusions described in **LIMITATIONS AND EXCLUSIONS**; and
- may require Preauthorization.

Professional Services

Services must be provided or arranged by the PCP (except for Virtual Visits) and rendered by a licensed Physician. 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 in **LIMITATIONS AND EXCLUSIONS**.

- **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 Participating Physicians when, in the judgment of the PCP or authorized Specialist, the nature of the illness or injury so indicates.
- **Virtual Visits.** Services provided for the treatment of conditions as described below in **Virtual Visits**. Virtual visits do not require Referral by the PCP and/or the HMO.

Services of Participating Physicians for 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.

COVERED SERVICES AND BENEFITS

Inpatient Hospital Services

Services, except Emergency Care and treatment of breast cancer, must be arranged by Your PCP and Preauthorized by HMO. Covered Services include:

1. semi-private room and board, with no limit to 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. blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for You;
13. short-term rehabilitation therapy services in an acute hospital settings;
14. 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 Preauthorization 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 HMO determines that an extension is Medically Necessary; and
15. organ and tissue transplants. Preauthorization is required for any organ or tissue transplant, even if the patient is already in a Hospital under another Preauthorization. At the time of Preauthorization, HMO will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if HMO determines that an extension is Medically Necessary.
 - a. Services, including donor expenses, for organ and tissue transplants are covered 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 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 of 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;

COVERED SERVICES AND BENEFITS

- (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 the PCP. Preauthorization may be required for the following services:

1. Infusion Therapy (including chemotherapy);
2. outpatient surgery;
3. radiation therapy; and
4. dialysis.

Outpatient Laboratory and X-Ray Services

Laboratory and radiographic procedures, services and materials, including (but not limited to) diagnostic x-rays, x-ray therapy, chemotherapy, fluoroscopy, electrocardiograms, laboratory tests and therapeutic radiology services must be ordered, authorized or arranged by the PCP and provided through a Participating facility. Preauthorization may be required.

Rehabilitation Services and Habilitation 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 preauthorized 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 and Habilitation 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. Rehabilitation Services and Habilitation Services, including coverage for chiropractic services, are available from a Participating Provider when Preauthorized or prescribed by Your PCP.

Benefits are provided for Habilitation Services provided for a Member with a disabling condition when both of the following conditions are met:

- The treatment is administered by one of the following Participating Providers: a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental/Investigational.

Benefits for Habilitation Services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not Habilitation Services. A service that does not help the Member to meet functional goals in a treatment plan within a prescribed time frame is not a Habilitation Service.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of Habilitation Services, are described under **Durable Medical Equipment and Prosthetic Appliances and Orthotic Devices**.

COVERED SERVICES AND BENEFITS

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, 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.

Except for treatment of Acquired Brain Injury, Rehabilitation Services and Habilitation Services are limited as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

Maternity Care and Family Planning Services

Maternity Care. 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. Preauthorization 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 Preauthorization, include:

1. prenatal visits;
2. use of Hospital delivery rooms and related facilities. A separate Hospital admission Copayment/Coinsurance is required for a newborn child at 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 Deductible for such readmission will be required.;
3. use of newborn nursery and related facilities;
4. special procedures as may be Medically Necessary and authorized by the PCP or designated Obstetrician/Gynecologist; and
5. 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. HMO may require the newborn to be transferred to a Participating facility, at 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 treatment for any other physical illness and may require Preauthorization.

Family Planning. Covered Services, which may require Preauthorization, 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 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 vasectomy and tubal ligation.

Note: some benefits for family planning are available under **Health Maintenance and Preventive Services**.

Infertility Services. Covered Services, which may require Preauthorization, include diagnostic counseling, consultations, planning services and treatment for problems of fertility and Infertility, subject to the exclusions in **LIMITATIONS AND EXCLUSIONS**. Once the Infertility workup and testing have been completed, subsequent workups and testing will require approval of the HMO Medical Director.

COVERED SERVICES AND BENEFITS

Elective Abortion Services. Elective abortions in the case of rape or incest, or for a pregnancy which, as certified by a Physician, places the woman in danger of death unless an abortion is performed (i.e., abortions for which federal funding is allowed) are covered.

Behavioral Health Services

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

Inpatient Mental Health Care. Covered Services include inpatient Mental Health Care when authorized by 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.

Services in a Residential Treatment Center for Children and Adolescents, a Residential Treatment Center or a Crisis Stabilization Unit are available only when the 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.

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

Chemical Dependency Services. Coverage for treatment of Chemical Dependency is the same as coverage for treatment of any other **Behavioral Health Services**, but is restricted as described in **LIMITATIONS AND EXCLUSIONS**. Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Some services may require Preauthorization by 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. HMO will pay for a medical screening examination or other evaluation required by 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. Emergency Care services whether rendered by a Participating or non-Participating Providers 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 Deductible, unless You are admitted as an inpatient directly from the emergency room, in which case You pay the inpatient Hospital Copayment and any amounts due.

If post stabilization care is required after an Emergency Care condition has been treated and stabilized, the treating Physician or Provider will contact HMO or its designee, who must approve or deny coverage of the post stabilization care requested within one hour of receiving the call.

Notwithstanding anything in this Evidence of Coverage to the contrary, for Emergency Care rendered by Providers who are not part of HMO's network of Participating Providers (non-Participating Provider) or otherwise contracted with HMO, the Allowable Amount shall be equal to the greatest of the following possible amounts—not to exceed billed charges:

1. the median amount negotiated with Participating Providers for emergency services furnished;
or

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2. the amount for the Emergency Care service calculated using the same method HMO generally uses to determine payments for non-Participating Provider services by substituting the Participating Providers cost-sharing provisions for the non-Participating Providers cost sharing provisions; or
3. the amount that would be paid under Medicare for the Emergency Care; or
4. the agreed rate, or usual and customary rate.

Each of these amounts is calculated excluding any in-network Copayment/Coinsurance and Deductible imposed with respect to the Member.

You may receive Emergency Care services in an Urgent Care center.

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.

Urgent Care Services

Urgent Care services are covered when rendered by a Participating 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 in **Outpatient Laboratory and X-ray Services** or **Outpatient Facility Services** may also apply.

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

Virtual Visits

Virtual Visits provide You with access to Virtual Network Providers that can provide diagnosis and treatment of non-emergency medical and behavioral health conditions in situations that can be handled without a traditional PCP office visit, behavioral health office visit, Urgent Care visit or Emergency Care visit. Covered Services may be provided via a consultation with a licensed medical professional through interactive audio via telephone or interactive audio-video via online portal or mobile application. For information on accessing this service, You may access the website at www.bcbstx.com or contact customer service at the toll-free number on the back of Your identification card. A PCP Referral is not required to obtain Covered Services.

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

Ambulance Services

For Emergency Care (as defined in this Evidence of Coverage) professional local ground ambulance services or air ambulance services to the nearest Hospital appropriately equipped and staffed for treatment of the Member's condition is covered. For non-Emergency Care, professional local ground ambulance services or air ambulance services is covered, when Medically Necessary and authorized by the PCP, to or from a facility appropriately equipped and staffed for treatment of the 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. The Member's condition must be such that any other form of transportation would be medically contraindicated.

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Air ambulance services are only covered when authorized by the PCP or 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 the PCP and authorized by the HMO. Services may have additional limitations as indicated on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and restrictions or exclusions described in **LIMITATIONS AND EXCLUSIONS**.

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 the PCP discharges You or after You reach the maximum benefit period or period authorized by 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 HMO, and is focused on a palliative rather than curative treatment. Services include bereavement counseling. For care provided in a Hospital, charges described in **Inpatient Hospital Services** 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 the PCP.

Health Maintenance and Preventive Services

Covered Services, which may require Preauthorization and will not be subject to any 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") or as required by state law:

1. well child care for Members through age seventeen (17) 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 eighteen (18) 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 and 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 and any other immunization that is required by the law for a child. (Allergy injections are not considered immunizations under this benefit provision.);
4. a physical exam and an annual prostate-specific antigen (PSA) test (once every twelve months) for the detection of prostate cancer for male Members who are at least fifty (50) years of age and asymptomatic; or at least forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor;
5. 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;

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6. 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;
7. 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;
8. 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 Deductible:

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 and vaginal contraceptive devices. This list may change as FDA guidelines, medical management and medical policies are modified. NOTE: Prescription contraceptive medications are covered under **PHARMACY BENEFITS**.

To determine if a specific contraceptive drug or device is available under this Preventive Services benefit contact customer service at the toll-free 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 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 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 Evidence of Coverage, and may be subject to any applicable Copayments/Coinsurance and Deductible.

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 (or, at HMO's option, the purchase) of manual or electric breast pumps and supplies. Limited benefits will also be available for the rental (or, at HMO's option, the purchase) of hospital grade breast pumps from a Participating Provider. You may be required to pay the full amount and submit a reimbursement claim form along with the written prescription to 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 on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

9. a screening test for hearing loss for Members from birth through age thirty (30) days, and necessary diagnostic follow-up care related to the screening test from birth through age twenty-four (24) months; and

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10. a medically recognized diagnostic rectal screening exam for the detection of colorectal cancer for Members age fifty (50) or older. Covered Services include a fecal occult blood test once every twelve months, a flexible sigmoidoscopy with hemoccult of the stool every five (5) years and a colonoscopy every ten (10) years.

Examples of other covered preventive services that are not subject to Copayment/Coinsurance, Deductible or dollar maximums include smoking cessation counseling services (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 Practitioner.

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, HMO may use reasonable medical management techniques to determine benefits. For more information, contact customer service at the toll-free 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 Copayment/Coinsurance and any applicable Deductible 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 Copayment/Coinsurance and any applicable Deductible for the office visit including the preventive health service.

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

1. eye and ear screenings (once every twelve months) performed or authorized by the PCP for Members through age seventeen (17) to identify vision and hearing problems. Eye screenings may be performed in the PCP office and do not include refractions;
2. eye and ear screenings (once every two years) performed or authorized by the PCP for Members eighteen (18) and older to identify vision and hearing problems. Eye screenings may be performed in the PCP office and do not include refractions;

Note: Covered children to age 19 do have additional benefits as described in **PEDIATRIC VISION CARE BENEFITS**.

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 on the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**.

4. early detection test for ovarian cancer. Benefits are available for a CA 125 blood test once every twelve months for female Members age eighteen (18) and older. Your PCP or any Obstetrician/Gynecologist in Your PCP's network of Participating Provider may administer the test.

Limitations: To the extent that providing coverage for ovarian cancer screening under Chapter 1370 of the Texas Insurance Code would otherwise require the State of Texas to make a payment under 42 U.S.C. Section 18031(d)(3)(B)(ii), a qualified health plan, as defined by 45 C.F.R. Section 155.20, is not required to provide a benefit for the ovarian cancer screening under Chapter 1370 of the Texas Insurance Code that exceeds the specified essential health benefits required under 42 U.S.C. Section 18022(b).

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Dental Surgical Procedures

General dental services are not covered, but limited oral surgical procedures are covered when prescribed by Your PCP and performed in a Participating Provider's office or in the inpatient or outpatient setting. The following Covered Services may require Preauthorization by HMO:

1. treatment for accidental injury and such 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, when treatment is completed within twenty-four (24) months of the initial treatment. "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 developmental defect, or a pathology;
5. services provided which are necessary for treatment or correction of a congenital defect; and
6. 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 Your PCP, and may require Preauthorization by HMO. Covered Services are limited to the following:

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

Allergy Care

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

Diabetes Care

Diabetes Self-Management Training. Covered Services, which may require Preauthorization, 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.

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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 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** in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences as well as any Deductibles. No claim forms are required.

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

- blood glucose monitors
- noninvasive glucose monitors and monitors for the blind
- insulin pumps and necessary accessories
- insulin infusion devices
- biohazard disposable containers
- podiatric appliances (including up to two pairs of therapeutic footwear per Calendar Year)

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** in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences as well as any Deductibles. No claim forms are required.

- glucose meter solution
- test strips specified for use with a corresponding blood glucose monitor
- visual reading and urine test strips and tablets that test for glucose, ketones and protein
- lancets and lancet devices
- injection aids, including devices used to assist with insulin injection and needleless systems
- glucagon emergency kits
- prescription orders for insulin and insulin analog preparations
- insulin syringes
- prescriptive and nonprescriptive oral agents for controlling blood sugar levels

Prosthetic Appliances and Orthotic Devices

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

1. Initial Prosthetic Appliances are covered subject to restrictions in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and **LIMITATIONS AND EXCLUSIONS**.
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. Initial breast prostheses and two surgical brassieres after mastectomy.
5. Medically Necessary foot orthotics that are consistent with the Medicare Benefit Policy Manual are covered. There is no Calendar Year maximum. This is in addition to, and does not affect, the coverage for podiatric appliances shown in **Diabetes Care**.

Durable Medical Equipment

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

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Examples of DME are: standard wheelchairs, crutches, walkers, orthopedic tractions, Hospital beds, oxygen, bedside commodes, suction machines, etc. Excluded items are listed in **LIMITATIONS AND EXCLUSIONS**.

Hearing Aids

Covered Services and equipment, which may require Preauthorization, include one audiometric examination to determine type and extent of hearing loss once every thirty-six (36) months and the fitting and purchase of hearing aid device(s). Exclusions are listed in **LIMITATIONS AND EXCLUSIONS**.

Speech and Hearing Services

Covered Services, which may require Preauthorization, 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.

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 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 in this Evidence of Coverage and any benefit exclusions or limitations will apply.

Autism Spectrum Disorder

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

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

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

Treatment may include services such as:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;

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- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

All standard contractual provisions of this Evidence of Coverage will apply, including but not limited to, defined terms, limitations and exclusions.

Routine Patient Costs for Participants in Certain Clinical Trials

Covered Services for Routine Patient Care Costs, as defined in **DEFINITIONS** 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 is 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 the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial. Services must be provided or arranged by the PCP.

Sample

LIMITATIONS AND EXCLUSIONS

The following benefits are not covered unless specifically provided for in **COVERED SERVICES AND BENEFITS** or **PHARMACY BENEFITS**.

1. Services or supplies of non-Participating Providers or self-referral to a Participating Provider, except:
 - a. Emergency Care;
 - b. when authorized by HMO or Your 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 the PCP or 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, HMO will not cover any services related to it. 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.
5. Any charges resulting from the failure to keep a scheduled visit with a Participating Provider or for 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 scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
14. Any services, supplies or drugs received by a Member outside of the United States, except for Emergency Care.
15. Transportation services except as described in **Ambulance Services**, or when approved by HMO.

LIMITATIONS AND EXCLUSIONS

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, 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 in **Inpatient Hospital Services**. 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 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, except when determined to be Medically Necessary and ordered or authorized by the 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 HMO;
 - b. dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases;
 - c. as described in **Diabetes Care**;
 - d. as described in **Autism Spectrum Disorder**; or
 - e. as described in **Therapies for Children with Developmental Delays**.
23. Services or supplies for Cosmetic, Reconstructive or Plastic Surgery, including breast reduction or augmentation (enlargement) surgery, even when Medically Necessary, except as described in **Cosmetic, Reconstructive or Plastic Surgery**.
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.
25. Services or supplies provided for, in preparation for, or in conjunction with the following, except as described in **Maternity Care and Family Planning Services**.
 - 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, artificial insemination, intrauterine insemination super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer and tubal embryo transfer;
 - 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. Services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.

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28. 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 **Preventive Services**.
29. Services or supplies for, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
30. Services or supplies for dental care, except as described in **Dental Surgical Procedures**.
31. 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 in **Dental Surgical Procedures**.
32. Alternative treatments such as acupuncture, acupressure, hypnotism, massage therapy and aroma therapy.
33. Services or supplies for:
 - a. intersegmental traction;
 - b. surface EMGs;
 - c. spinal manipulation under anesthesia;
 - d. muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
34. Galvanic stimulators or TENS units.
35. 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 and bandages, garter belts, ostomy bags.
36. Prosthetic Appliances or orthotic devices not described in **Diabetes Care** or **Prosthetic Appliances and Orthotic Devices** 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 affect changes in the foot or foot alignment; arch supports; braces; splints or other foot care items.
37. 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;
 - j. bioenergetic therapy; or
 - k. psychotherapeutic services accessed concurrently by more than one Mental Healthcare Provider.

LIMITATIONS AND EXCLUSIONS

38. Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.
39. Mental health services except as described in **Behavioral Health Services** or as may be provided under **Autism Spectrum Disorder**.
40. 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.
41. Trauma or wilderness programs for behavioral health or Chemical Dependency treatment.
42. 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).
43. 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.
44. 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 **Autism Spectrum Disorder**;
 - c. as provided under **Diabetes Care**;
 - 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 **PHARMACY BENEFITS**.
45. Telemedicine Medical Services or Telehealth Services, except as described in **Virtual Visits**.
46. Any procedures, equipment, services, supplies, or charges for abortions for which Federal funding is prohibited. Federal funding is allowed for abortions where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a Physician, places You in danger of death unless an abortion is performed.
47. 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.

PHARMACY BENEFITS

Definitions

In addition to the applicable terms provided in the **DEFINITIONS** section of this Evidence of Coverage, 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.

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

Copayment or **Copay** means the dollar 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.

Drug List means a list of all 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 and corresponding Member Copayment responsibility, HMO utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. The Drug List identifying preferred and non-preferred Generic Drugs is available by accessing the website at www.bcbstx.com/member/rx_drugs; 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.

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

Non-Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable Drug List and is subject to the Non-Preferred Brand Name Drug Copayment. The Drug List is available by accessing the website at www.bcbstx.com/member/rx_drugs.

Participating Pharmacy means an independent retail Pharmacy, or chain of retail Pharmacies, or 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 Evidence of Coverage.

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 BENEFITS

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

Preferred Brand Name Drug means a Brand Name Drug which appears on the applicable Drug List and is subject to the Preferred Brand Name Drug Copayment. This list is available by accessing the website at www.bcbstx.com/member/rx_drugs.

Preferred Participating Pharmacy means a Participating Pharmacy which has a written agreement with HMO to provide pharmaceutical services to Members or an entity chosen by HMO to administer its prescriptions drug program that has been designated as a Preferred Participating Pharmacy.

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 high cost prescription drug that meets any of the following criteria;

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

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

PHARMACY BENEFITS

Covered Drugs

Benefits for Medically Necessary covered drugs prescribed to treat You for a chronic, disabling, or life-threatening illness covered by 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 HMO, may be eligible for benefits if included on the applicable Drug List. Some drugs are manufactured under multiple brand names and have many therapeutic equivalents. Generic medications may also have several therapeutic equivalents. In such cases, HMO may limit benefits to specific therapeutic equivalents

You are responsible for any Copayments/Coinsurance and any Deductible for covered drugs shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and pricing differences that may apply to the covered drug dispensed.

Injectable Drugs. Injectable drugs approved by the FDA for self-administration are covered. Injectable drugs include, but are not limited to, insulin and lmitrex.

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

Diabetes Supplies for 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 Deductible will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

Preventive Care. Over-the-counter drugs which have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”) or as required by state law will be covered and will not be subject to any Copayment, Coinsurance, Deductible or dollar maximums.

Vaccinations obtained through certain Participating Pharmacies. Benefits for vaccinations are shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. These vaccinations are available through certain Participating Pharmacies that have contracted with 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.

Each Participating Pharmacy included in the Pharmacy Vaccine Network that has contracted with HMO to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases. Dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases are covered.

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.

PHARMACY BENEFITS

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.

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 and any Deductible shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences. 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 (Provider Finder).

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 Deductible shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences, payable by 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, access the website at www.bcbstx.com/member/rx_drugs 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.

The HMO Specialty Pharmacy Program delivery service offers:

- Coordination of coverage between You, Your Health Care Practitioner and 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/member/rx_drugs or by contacting customer service at the toll-free number on Your identification card. Your cost will be the applicable Copayment/Coinsurance and any Deductible shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** as well as any applicable pricing differences.

Prescription Drugs Purchased Outside of the Service Area. HMO will reimburse You for the Allowable Amount of the prescription drugs less the Out-of-Area Drug Copayment/Coinsurance shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**, for covered prescription drugs which You purchase outside of the Service Area. You must submit a completed claim form to HMO, including Your name, the prescribing authorized Health Care Practitioner's name, the date of purchase, NDC of the drug, and itemized receipts indicating the total cost of the prescription within ninety (90) days of the date of purchase to qualify for reimbursement under the **PHARMACY BENEFITS**. You may access the website at www.bcbstx.com/member/rx_drugs to obtain a prescription drug claim form. Any Deductible shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** will also apply.

PHARMACY BENEFITS

Your Cost

How Copayment/Coinsurance Amounts Apply. If the Allowable Amount of the drug is less than the Copayment/Coinsurance, You pay the lower cost. You will pay no more than the applicable Preferred Brand Name Drug or Non-Preferred Brand Name Drug Copayment/Coinsurance if the prescription has no generic equivalent. If You receive a Brand Name Drug when a generic equivalent is available, the Copayment/Coinsurance will be the total of the Generic Drug Copayment/Coinsurance plus the difference between the cost of the Generic Drug equivalent and the cost of the Brand Name Drug. You will also be responsible for any Deductible that may apply. Exceptions to this may be allowed for certain preventive medications (including prescription contraceptive medications) if Your Health Care Practitioner submits a request to HMO indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If HMO grants the exception request, any difference between the Allowable Amount for the Brand Name Drug and the Generic Drug equivalent will be waived.

Deductible. The Deductible per Calendar Year for each Member is shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. This is the dollar amount that each Member must pay during a Calendar Year before benefits are available. This Deductible will be applied to each covered Prescription Order filled or refilled until it is satisfied and will be based on the Allowable Amount of the drugs. After the Deductible is met, You will only pay the appropriate Copayment/Coinsurance for covered drugs and any pricing difference that may apply.

Drug Coupons, Rebates, and Other Discounts. Third parties, including but not limited to drug manufacturers, may offer drug coupons, rebates or other drug discounts to Members, which may impact the benefits provided under this Evidence of Coverage. HMO does not accept cost-sharing payments from any third parties. These drug coupons, rebates and other discounts may not be applied towards Your Deductible or Your out-of-pocket maximum.

About Your Benefits

Covered Drug List. A list of all covered drugs is shown on the Drug List. HMO will periodically review the Drug List and adjust it to modify the preferred/non-preferred Brand Name Drug status of new and existing drugs. The Drug List and any modifications thereto will be made available to Members. This list is available by accessing the website at www.bcbstx.com/member/rx_drugs or by contacting customer service at the toll-free number on Your identification card.

Exception Requests. You, or Your prescribing Health Care Practitioner, can ask for a Drug List exception if Your drug is not on the Drug List (also known as a formulary). To request this exception, You, or Your prescriber, can call the number on the back of Your identification card to ask for a review. If You have a health condition that may jeopardize Your life, health or keep You from regaining function, or Your current drug therapy uses a non-covered drug, You, or Your prescriber, may be able to ask for an expedited review process. HMO will let You, and Your prescriber, know the coverage decision within 24 hours after they receive Your request for an expedited review. If the coverage request is denied, HMO will let You and Your prescriber know why it was denied and offer You a covered alternative drug (if applicable). If Your exception is denied, You may appeal the decision according to the appeals process You will receive with the denial determination. Call the number on the back of Your 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 in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS**. HMO has the right to determine the day supply. Payment for benefits covered by 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.

If You are leaving the country or need an extended supply of medications, call customer service at least two weeks before You intend to leave. Extended supplies or vacation override are not available through the mail-order program, but may be approved through the retail Pharmacy only. In some cases, You may be asked to provide proof of continued membership eligibility under the Evidence of Coverage.

Dispensing/Quantity Versus Time Limits. The maximum quantity of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, You may access the website at www.bcbstx.com or contact customer service at the toll-free number on Your identification card.

PHARMACY BENEFITS

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

If You require a Prescription Order in excess of the dispensing limit established by 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/provider. Any pertinent medical information along with the completed form should be faxed to Clinical Pharmacy Programs at the fax number indicated on the form. The request will be approved or denied after evaluation of the submitted clinical information. HMO has the right to determine dispensing limits at its sole discretion. Payment for benefits covered by 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.

Controlled Substance Limits. In the event HMO determines that a Member may be receiving quantities of a Controlled Substance not supported by FDA approved dosages or recognized treatment guidelines, any additional drugs may be subject to a review for medical necessity, appropriateness and other coverage restrictions such as limiting coverage to services by a certain Provider and/or Participating Pharmacy for the prescribing and dispensing of the Controlled Substance.

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 that may be less costly for you prior to those medications on the step therapy list of drugs being covered under HMO.

When You submit a Prescription Order to a Participating Pharmacy for one of these designated medications, the pharmacist will be alerted if the online review of Your prescription claims history indicates an acceptable alternative medication has not been previously tried. If so, a toll-free phone number will be provided to You for Your Health Care Practitioner to call and obtain additional program and criteria information. A list of step therapy medications is available to You and Your Health Care Practitioner on our website at www.bcbstx.com/provider 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 or drug classes subject to the step therapy program without trying an alternative medication first. In this case, Your Health Care Practitioner must contact 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/Coinsurance and after any Deductible.

Although You may currently be on step therapy, 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 generic or brand therapeutic alternative medication may be required for continued coverage of the Brand Name Drug.

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/provider 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/provider. The requested medication may be approved or denied for coverage by HMO based upon its accordance with established clinical criteria.

Right of Appeal. You have the right to appeal as explained in the **COMPLAINT AND APPEAL PROCEDURES** section of this Evidence of Coverage.

PHARMACY BENEFITS

Limitations and Exclusions

Pharmacy benefits are not available for:

1. Drugs that are not shown on the Drug List.
2. Drugs which by law do not require a Prescription Order, except as indicated under **Preventive Care** in **PHARMACY BENEFITS**, 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 vaccinations administered through certain Participating Pharmacies shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** are covered.)
3. 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 HMO.
4. 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.
5. Drugs, that the use or intended use of would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
6. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the identification card.
7. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction that is not covered under HMO, or for which benefits have been exhausted.
8. 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 or custodial or chronic care institution or facility.
9. Drugs for which the Pharmacy's usual retail price to the general public is less than or equal to the Copayment.
10. Drugs purchased from a non-Participating Pharmacy in the Service Area.
11. 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, syringes for self-administered injections and contraceptive devices are covered). However, You do have certain DME benefits available under the **Durable Medical Equipment** section in **COVERED SERVICES AND BENEFITS**. Coverage for female contraceptive devices and the rental (or, at HMO's option the purchase) of manual or electric breast pumps is provided as indicated under the Health Maintenance and Preventives Services section in **COVERED SERVICES AND BENEFITS**.
12. 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.
13. Any special services provided by a Pharmacy, including but not limited to counseling and delivery. Vaccinations shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** administered through certain Participating Pharmacies are an exception to this exclusion.
14. Drugs dispensed in quantities in excess of the day supply amounts indicated in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** 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.
15. Administration or injection of any drugs.
16. Injectable drugs except Specialty Drugs or those approved by the FDA for self-administration.

PHARMACY BENEFITS

17. 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.
18. 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.)
19. Fluids, solutions, nutrients or medications (including all additives and chemotherapy) used or intended to be used by intravenous or intramuscular injection (unless approved by the FDA for self-administration), intrathecal, intraarticular injection or gastrointestinal (enteral) infusion in the home setting.
20. Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative or as indicated under **Preventive Care** in **PHARMACY BENEFITS**).
21. Allergy serum and allergy testing materials. However, You do have certain benefits available under Allergy Care in **COVERED SERVICES AND BENEFITS**.
22. Athletic performance enhancement drugs.
23. 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.
24. Any prescription antiseptic or fluoride mouthwashes, mouth rinses or topical oral solutions or preparations.
25. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
26. Retin A or pharmacologically similar topical drugs.
27. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.
28. Drugs to treat sexual dysfunction including but not limited to sildenafil citrate, phentolamine, apomorphine, and alprostadil in oral and topical form.
29. Drugs for the treatment of Infertility (oral and injectable).
30. Prescription Orders which do not meet the required step therapy criteria.
31. Prescription Orders which do not meet the required prior authorization criteria.
32. Some drugs are manufactured under multiple brand names and have many therapeutic equivalents. Generic medications may also have several therapeutic equivalents. In such cases, HMO may limit benefits to specific therapeutic equivalents. If You do not accept the therapeutic equivalents that are covered under this Evidence of Coverage, the drug purchased will not be covered under any benefit level.
33. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
34. Shipping, handling or delivery charges.
35. Brand Name Drugs in a drug class where there is an over-the-counter alternative available.
36. Prescription Orders written by a member of Your immediate family, or a self-prescribed Prescription Order.
37. Drugs which are repackaged by anyone other than the original manufacturer.
38. Drugs determined by HMO to have inferior efficacy or significant safety issues.

GENERAL PROVISIONS

Termination of Coverage

If this Evidence of Coverage is terminated for nonpayment of Premium, Your coverage shall be terminated effective after the last day of the grace period. In the event You are receiving a Premium Tax Credit, You have a three-month grace period, or such other grace period, if any, permitted by applicable law or regulatory guidance. Only Members for whom the stipulated payment is actually received by 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 in the event that Premium payments are not made by You. Refer to **HOW THE PLAN WORKS** for additional information regarding grace periods.

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

Non-Renewal of All Coverage

- HMO may not renew this Evidence of Coverage if HMO elects to discontinue this type of coverage issued hereunder in the Service Area, but only if coverage is discontinued uniformly without regard to the health status related factors of a covered individual. HMO may cancel coverage after ninety (90) days prior written notice of termination, or such other notice, if any, permitted by applicable law or regulatory guidance. HMO must offer each Member on a guaranteed issue basis the option to purchase any other individual coverage offered by the HMO in the same Service Area.
- HMO may elect to discontinue all individual HMO contracts issued in the Service Area, but only if coverage is discontinued uniformly without regard to the health status related factors of a covered individual. HMO may cancel coverage after one hundred eighty (180) days prior written notice of termination, or such other notice, if any, permitted by applicable law or regulatory guidance.

Member Termination in a Qualified Health Plan

If your coverage in this QHP is terminated by HMO, You will be provided with a written notice of termination of coverage, or such other notice, if any, permitted by applicable law or regulatory guidance that includes the reason for termination. HMO will also notify the Exchange of the termination.

You and your covered Dependent's coverage will be terminated due to the following events and will end on the dates specified below:

1. You terminate Your coverage in this QHP, including as a result of your obtaining other Minimum Essential Coverage, with reasonable, appropriate notice to the Exchange and HMO. For the purposes of this section, reasonable notice is defined as 14 days from the requested effective date of termination.

The last day of coverage will be:

- The termination date specified by You, if You provide reasonable notice;
 - 14 days after the termination is requested by You, if You do not provide reasonable notice; or
 - On a date determined by HMO, if HMO is able to effectuate termination in fewer than 14 days and You request an earlier termination effective date.
2. When You are no longer eligible for QHP coverage through the Exchange. The last day of coverage is the last day of the month following the month in which the notice is sent by the Exchange unless You request an earlier termination effective date.
 3. When HMO does not receive the Premium payment on time (Refer to **HOW THE PLAN WORKS**; Premium Payments for additional information).
 4. Your coverage has been rescinded.

GENERAL PROVISIONS

5. You change from one QHP to another during an annual Open Enrollment Period or special enrollment period. The last day of coverage in your prior QHP is the day before the effective date of coverage in your new QHP.
6. Events otherwise provided for under federal or state law or as Exchange rules may dictate.

Member Termination by HMO

HMO may terminate this Evidence of Coverage for a Member in the case of:

Cause	Effective Date of Termination
(1) Fraud or intentional misrepresentation of a material fact, except as described in Incontestability of this Evidence of Coverage	After fifteen (15) days written notice
(2) Fraud in the use of services or facilities	After fifteen (15) days written notice
(3) Failure to meet eligibility requirements	Immediately
(4) A Member not residing, living or working in the Service Area of the HMO, but only if coverage is terminated uniformly without regard to any health status-related factor of the Member.	After thirty (30) days written notice, except for a child who is subject of a medical support order and cannot be terminated solely because the child does not reside, live or work in the Service Area

In the event that there is a conflict between **Member Termination in a Qualified Health Plan** and **Member Termination by HMO** sections above, the provision that is most favorable to the Member will apply.

Renewal of Member Coverage. HMO will renew Your Evidence of Coverage unless You were terminated under Termination of Coverage; Member Termination by HMO.

Continuation of Coverage

If a covered person's coverage terminates due to a change in marital status You may be issued coverage that most nearly approximates the coverage of the Evidence of Coverage which was in effect prior to the change in marital status without furnishing evidence of insurability. In order to convert, You must continue to reside, live or work in the Service Area, submit a completed application within thirty-one (31) days after the date of the change in marital status and submit Premium payments required under such Evidence of Coverage. The effective date of such coverage shall be the Effective Date of Coverage under the prior Evidence of Coverage.

Reinstatement

In any case where termination resulted from failure to make timely payment of Premium, the subsequent acceptance of such Premium payments by HMO or our duly authorized agents shall reinstate the coverage. For purposes of this provision, mere receipt and/or negotiation of a late Premium payment does not constitute acceptance. The reinstated Evidence of Coverage shall cover only loss resulting from injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than ten days after such date. In all other respects, the Subscriber and HMO shall have the same rights hereunder as they had under the Evidence of Coverage immediately before the due date of the defaulted Premiums, including the right of the Subscriber to apply the period of time this Evidence of Coverage was in effect immediately before the due date of the defaulted Premiums toward satisfaction of any waiting periods for benefits, if any, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any Premium payments accepted in connection with a reinstatement shall be applied to a period for which Premiums have not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

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Coordination of Benefits

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

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

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

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

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

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

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

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 Evidence of Coverage 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 Evidence of Coverage.
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.

GENERAL PROVISIONS

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

GENERAL PROVISIONS

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 Evidence of Coverage, HMO will pay the difference between benefits under this Evidence of Coverage and benefits under the previous contract or insurance policy for services on or after the effective date of this Evidence of Coverage.

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

For purposes of this provision, HMO may, subject to applicable confidentiality requirements set forth in this Evidence of Coverage, release to or obtain from any insurance company or other organization necessary information under this provision. If You claim benefits under this Evidence of Coverage, 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 Evidence of Coverage.

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.

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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 Evidence of Coverage may be reduced accordingly.

Reimbursement - Acts of Third Parties

HMO will provide services to You due to the act or omissions 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 Evidence of Coverage. 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.

Sample

GENERAL PROVISIONS

Assignment

This Evidence of Coverage is not assignable by a Member without the written consent of HMO.

Cancellation

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

Clerical Error

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

Entire Evidence of Coverage

This Evidence of Coverage, any attachments, amendments, and the 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 Evidence of Coverage 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 Evidence of Coverage 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.

Former Content of Evidence of Coverage

No agent or employee of HMO is authorized to change the form or content of this Evidence of Coverage 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 Evidence of Coverage, 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).

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 application signed by Subscriber and a signed copy of the 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.

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Interpretation of Evidence of Coverage

The laws of the state of Texas shall be applied to interpretations of this Evidence of Coverage. Where applicable, the interpretation of this Evidence of Coverage shall be guided by the direct-service nature of HMO's operations as opposed to a health insurance program. If the Evidence of Coverage contains any provision not in conformity with the Texas Health Maintenance Organization Act or other applicable laws, the Evidence of Coverage 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 interpretation 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 Evidence of Coverage, or in the performance of any duty of responsibility contemplated by this Evidence of Coverage, shall be limited to the maximum benefits which should have been paid under the Evidence of Coverage 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.

Modifications

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

Non-Agency

The Subscriber understands that this Evidence of Coverage constitutes an Evidence of Coverage solely between the Member and Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. The license from the Association permits Blue Cross and Blue Shield of Texas to use the Blue Cross and Blue Shield Service Marks in the State of Texas. BCBSTX is not contracting as the agent of the Association. The Member also understands that he has not entered into this Evidence of Coverage based upon representations by any person other than BCBSTX. No person, entity, or organization other than BCBSTX shall be held accountable or liable to the Member for any of its obligations created under this Evidence of Coverage. This section shall not create any additional obligations whatsoever on the part of BCBSTX other than those obligations created under other provisions of this Evidence of Coverage.

Notice

Any notice under this Evidence of Coverage may be given by United States mail, first class, postage prepaid, addressed as follows:

- If to HMO, to the address on the face page of this Evidence of Coverage.
- If to You, at the last address known to HMO
- Or electronically if by an agreement between HMO and the Member.

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.

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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.

If this plan is purchased through the Exchange, in no event shall HMO be considered the agent of the Exchange or be responsible for the Exchange. All information You provide to the Exchange and received by HMO from the Exchange will be relied upon as accurate and complete. The Member will promptly notify the Exchange and HMO of any changes to such information.

Reports and Records

HMO is entitled to receive from any Provider of services to Members, information reasonably necessary to administer this Evidence of Coverage subject to all applicable confidentiality requirements described below. By accepting coverage under this Evidence of Coverage, 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 of Coverage

Rescission is the retroactive cancellation or discontinuance of coverage due to an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact by You or by a person seeking coverage on Your behalf. 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, a cancellation initiated by the Exchange, 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 Evidence of Coverage, HMO may at its option make an offer to reform the Evidence of Coverage already in force and/or change the rating category/level. In the event of reformation, the Evidence 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.

Subtitles

The subtitles included within this Evidence of Coverage are provided for the purpose of identification and convenience and are not part of the complete Evidence of Coverage as described in Entire Evidence of Coverage.

GENERAL PROVISIONS

Transfer of Residence

- **Within the HMO Service Area:** If Subscriber changes primary residence, notification must be made to HMO and the Exchange within sixty (60) days of such change.
- **Outside the HMO Service Area:** If Subscriber no longer resides or works in the Service Area, such change will result in loss of eligibility and Subscriber must notify HMO and the Exchange within sixty (60) days of such change.

Actuarial Value

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health benefit plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his/her own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care providers and particular benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular benefit plan.

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 Subscriber. 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 Evidence of Coverage the Subscriber 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.

Premium Rebates and Premium Abatements

Rebate. In the event federal or state law requires Blue Cross and Blue Shield of Texas (BCBSTX) to rebate a portion of annual Premiums paid, BCBSTX will directly provide any rebate owed Subscribers or former Subscribers to such persons in amounts as required by law.

If any rebate is owed a Subscriber or former Subscriber, BCBSTX will provide the rebate to the Subscriber or former Subscriber no later than August 1 following the end of the medical loss ratio ("MLR") reporting year.

BCBSTX will provide any rebate owed to a Subscriber in the form of a Premium credit, lump-sum check or, if a Subscriber paid the premium using a credit card or direct debit, by lump-sum reimbursement to the account used to pay the Premium. However, BCBSTX will provide any rebate owed to a former Subscriber in the form of lump-sum check or lump-sum reimbursement using the same method used for payment, such as credit card or direct debit.

If a rebate is provided in the form of a Premium credit, BCBSTX will provide any rebate by applying the full amount due to the first Premium payment due on or after August 1 following the end of the MLR reporting year. If the rebate owed is greater than the Premium due, BCBSTX will apply any overage to succeeding Premium payments until the full amount of the rebate has been credited.

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At the time any rebate is provided, BCBSTX will provide to each BCBSTX Subscriber or former Subscriber who receives a rebate a notice containing at least the following information:

- (A) A general description of the concept of a MLR;
- (B) The purpose of setting a MLR standard;
- (C) The applicable MLR standard;
- (D) BCBSTX's MLR;
- (E) BCBSTX's aggregate premium revenue as reported under federal MLR regulations (minus any federal and state taxes and licensing and regulatory fees that may be excluded from premium revenue under those regulations); and
- (F) The rebate percentage and amount owed based upon the difference between the BCBSTX's MLR and the applicable MLR standard.

Abatement. BCBSTX may from time to time determine to abate (in whole or in part) the Premium due under this Contract for particular period(s).

Any abatement of premium by BCBSTX represents a determination by BCBSTX not to collect Premium for the applicable period(s) and does not effect a reduction in the rates under this contract. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

BCBSTX makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each Subscriber or former Subscriber (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

Identity Theft Protection

As a Member, BCBSTX 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 BCBSTX's designated outside vendor and acceptance or declination of these services is optional to the 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 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 or without notice and BCBSTX does not guarantee that a particular vendor or service will be available at any given time.

Value Based Design Programs

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

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

Contact Blue Cross and Blue Shield for additional information regarding any value based programs offered by Blue Cross and Blue Shield.

**ADDITIONAL
INFORMATION**

ADDITIONAL INFORMATION

AMERICAN INDIAN/ALASKAN NATIVE COST-SHARING NOTICE

If You are an American Indian/Alaskan Native enrolled under this plan, the following variations in cost-sharing amounts will apply to Your coverage under this Qualified Health Plan (QHP) offered on the Exchange:

If You have a household income of less than 300% of the Federal Poverty Level, You may be eligible for a Zero Cost Sharing (ZCS) Plan.

- If You are enrolled in a ZCS QHP with an out-of-network benefit, You will have Your cost-sharing for medical and drug essential health benefits reduced to zero when the benefit is provided at both In-Network and out-of-network Providers. Any Preauthorization requirements, balance billing/overage from non-contracting or out-of-network Providers, and any maximum benefit limitation or exclusions, will still apply.
- If You are enrolled in a ZCS QHP without an out-of-network benefit (e.g. HMO), You will have Your cost-sharing for medical and drug essential health benefits, as indicated in Your Evidence of Coverage, reduced to zero for in-network services only. Your ZCS QHP does not provide benefits for services received from an out-of-network Provider, so You may be responsible for all costs associated for services obtained from such a Provider. Any Preauthorization requirements, balance/overage from out-of-network Providers, and any maximum benefit limitations or exclusions, will still apply.

If You are not eligible for a ZCS Plan, You may be eligible for a Limited Cost Sharing (LCS) Plan.

- Under the LCS plans, You will have cost-sharing for medical and drug essential health benefits, as indicated in Your Evidence of Coverage, reduced to zero when You receive services from an Indian Health Service provider, other tribal or urban Indian organization provider (“I/T/U providers”), or through a referral issued by an I/T/U provider under the Contract Health Service (“CHS”) program. If You do not receive services from an I/T/U provider or through a CHS referral, You may be responsible for cost-sharing described in Your benefit materials. Any applicable Preauthorization requirements, balance billing/overage from out-of-network Providers, any maximum benefit limitations or exclusions, will still apply.

For information on whether a specific Provider is a Participating Provider or out-of-network Provider or whether a specific Provider is an IHS or other tribal or urban Indian organization provider, call a Customer Service Representative at the number located on the back of Your identification card.

**PEDIATRIC VISION
CARE BENEFITS**

PEDIATRIC VISION CARE BENEFITS

Pediatric Vision Care is made part of, and is in addition to any information You may have in Your HMO Evidence of Coverage. Information about coverage for the routine vision care services are outlined below and are specifically excluded under Your medical health care plan. (Services that are covered under Your medical plan are not covered under this *Pediatric Vision Care Benefit*.) All provisions in the Evidence of Coverage apply to *Pediatric Vision Care Benefits* unless specifically indicated otherwise below.

Definitions

Medically Necessary Contact Lenses: Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Provider – For purposes of this *Pediatric Vision Care Benefit*, a licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician.

Vision Materials – Corrective lenses and/or frames or contact lenses.

Eligibility

Children who are covered under Your Evidence of Coverage, to age 19, are eligible for coverage under this *Pediatric Vision Care Benefit*. NOTE: Once coverage is lost under Your Evidence of Coverage, all benefits cease under this *Pediatric Vision Care Benefit*.

Limitations and Exclusions

The limitations and exclusions in this section apply to all pediatric vision benefits. Although HMO may list a specific service as a benefit, HMO will not cover it unless we determine it is necessary for the prevention, diagnosis, care or treatment of a covered condition.

We do not cover the following:

- Any vision service, treatment or materials not specifically listed as a covered service;
- Services and materials that are experimental or investigational;
- Services and materials that are rendered prior to Your effective date;
- Services and materials incurred after the termination date of Your coverage unless otherwise indicated;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from Your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any charges for failure to keep a scheduled appointment;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Office infection control charges;
- Charges for copies of Your records, charts, or any costs associated with forwarding/ mailing copies of Your records or charts;
- State or territorial taxes on vision services performed;
- Medical treatment of eye disease or injury;
- Visual therapy;
- Special lens designs or coatings other than those described in this benefit;
- Replacement of lost/stolen eyewear;
- Non-prescription (Plano) lenses;
- Non-prescription sunglasses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;
- Insurance of contact lenses;
- Professional services You receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption;
- Orthoptic or vision training; Aniseikonic spectacle lenses.

PEDIATRIC VISION CARE BENEFITS

How the Vision Benefits Work

You may visit any Participating Provider and receive benefits for a vision examination and covered Vision Materials.

Before You go to a Participating Provider for an eye examination, eyeglasses, or contact lenses, please call ahead for an appointment. When You arrive, show the receptionist Your identification card. If You forget to take Your card, be sure to say that You are a Member of the HMO vision care plan so that Your eligibility can be verified.

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.

You may receive Your eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Participating Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Participating Provider and there may be additional professional charges if You seek contact lenses from a Participating Provider other than the one who performed Your eye examination.

Fees charged for services other than a covered vision examination or covered Vision Materials, and amounts in excess of those payable under this *Pediatric Vision Care Benefit*, must be paid in full by You to the Provider, whether or not the Provider participates in the vision care plan. These *Pediatric Vision Care Benefits* may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

Sample

PEDIATRIC VISION CARE BENEFITS

Schedule of Pediatric Vision Copayments and Benefit Limits

Vision Care Services	Member Cost or Discount (When a fixed-dollar Copay is due from the Member, the remainder is payable by HMO up to the covered charge*)	Out-of-Network Allowance (maximum reimbursement amount payable by HMO, not to exceed the retail cost)**
Exam (with dilation as necessary):	No Copay	\$30 reimbursement
Frames: Provider Designated frame	No Copay	\$75 reimbursement
Non-Provider Designated frame	You receive 20% off balance of retail cost over \$150 allowance	\$75 reimbursement
Frequency: Examination, Lenses/Frames, or Contact Lenses	Once every Calendar Year	
Standard Plastic, Glass, or Poly Spectacle Lenses: Single Vision Bifocal Trifocal Lenticular Note: Lenses include ultraviolet protective coating, fashion and gradient tinting, oversized and glass-grey #3 prescription sunglasses lenses.	No Copay No Copay No Copay No Copay	\$25 reimbursement \$40 reimbursement \$55 reimbursement \$55 reimbursement
Lens Options (added to lens prices above): Tint (Solid and Gradient) Standard Plastic Scratch Coating Standard Polycarbonate	No Copay No Copay No Copay	\$12 reimbursement \$12 reimbursement \$32 reimbursement
Contact Lenses: covered once every Calendar Year – in lieu of spectacle lenses Elective Conventional Disposable Medically Necessary Contact Lenses – Preauthorization is required Note: Additional benefits over allowance are available from Participating Providers.	You receive 15% off balance of retail cost over \$150 allowance \$150 allowance No Copay	\$150 reimbursement \$150 reimbursement \$210 reimbursement
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		

PEDIATRIC VISION CARE BENEFITS

Additional Benefits
Medically Necessary Contact Lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary Preauthorization for these services.
Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our Members with low vision. After Preauthorization, covered low vision services will include one comprehensive low vision evaluation every 5 years, low vision aid items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period. Participating Providers will obtain the necessary Preauthorization for these services.
Warranty: Warranty limitations may apply to provider or retailer supplied frames and/or eyeglass lenses. Please ask Your Provider for details of the warranty that is available to You.

- * The “covered charge” is the rate negotiated with Participating Providers for a particular covered service.
- ** HMO pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

Sample

AMENDMENTS