

Administered by:



**BlueCross BlueShield
of Texas**



Your Health Care Benefits Program

Managed Health Care
Pharmacy Benefits

Whirlwind Steel Buildings, Inc.
Group #081980

January 1, 2019

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SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> Calendar Year Deductible <i>Three-month Deductible carryover applies</i> 	\$750 – per individual \$2,250 – per family	\$750 – per individual \$2,250 – per family
Co-Share Stop-Loss Amounts	\$2,500 – per individual \$7,500 – per family	\$5,000 – per individual \$15,000 – per family
Copayment Amounts Required <ul style="list-style-type: none"> Physician office visit/consultation for Primary Care Providers Physician office visit/consultation for Specialty Care Providers Outpatient Hospital Emergency Room/Treatment Room visit Urgent Care Center visit Retail Health Clinic 	\$25 Physician office visit \$35 Physician office visit \$150 outpatient Hospital Emergency Room/Treatment Room visit \$50 Urgent Care Center visit \$25 Retail Health Clinic visit	Does Not Apply Does Not Apply \$150 outpatient Hospital Emergency Room/Treatment Room visit Does Not Apply Does Not Apply
Inpatient Hospital Expenses All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible No penalty for failure to preauthorize services	60% of Allowable Amount after Calendar Year Deductible \$250 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> Office visit/consultation (Primary Care Providers) including lab and x-rays Office visit/consultation (Specialty Care Providers) including lab and x-rays Radiation Therapy and Chemotherapy in the office setting Diabetic Management (training/nutritional) Inpatient visits and Certain Diagnostic Procedures Home Infusion Therapy Physician surgical services in any setting Allergy Injections (without office visit) Independent Lab & X-ray 	100% of Allowable Amount after \$25 Copayment Amount 100% of Allowable Amount after \$35 Copayment Amount 100% of Allowable Amount after \$25/\$35 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses <ul style="list-style-type: none"> • Skilled Nursing Facility • Home Health Care • Hospice Care 	80% of Allowable Amount 80% of Allowable Amount 80% of Allowable Amount	60% of Allowable Amount 60% of Allowable Amount 60% of Allowable Amount
Emergency Care Accidental Injury & Emergency Care <ul style="list-style-type: none"> • Facility Charges • Lab & X-ray without emergency room or treatment room • Physician Charges Non-Emergency Care <ul style="list-style-type: none"> • Facility Charges • Physician Charges 	100% of Allowable Amount up to \$500, then 80% after \$150 outpatient Hospital emergency room Copayment Amount (waived if admitted) 100% of Allowable Amount 80% of Allowable Amount after Calendar Year Deductible	
	80% of Allowable Amount after \$150 outpatient Hospital emergency room Copayment Amount (waived if admitted)	60% of Allowable Amount after Calendar Year Deductible and after \$150 outpatient Hospital emergency room Copayment Amount (waived if admitted)
	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Urgent Care Services <ul style="list-style-type: none"> • Urgent Care Center visit - including lab & x-ray services (excluding Certain Diagnostic Procedures) 	100% of Allowable Amount after \$50 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Retail Health Clinic	100% of Allowable Amount after \$25 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Preventive Care <ul style="list-style-type: none"> • Routine physical examinations, well baby care, Immunizations 6 years and over, routine lab, x-ray, vision and hearing exams • Colonoscopy Professional (physician charges) • Colonoscopy facility charges • Immunizations Birth up to age 6 	100% of Allowable Amount up to \$200, then 80% of Allowable Amount 100% of Allowable Amount	60% of Allowable Amount 100% of Allowable Amount
Speech and Hearing Services, excluding hearing aids <ul style="list-style-type: none"> • Office visit • All other services 	100% of Allowable Amount after \$25/\$35 Copayment Amount 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Chiropractic Services		
<ul style="list-style-type: none"> • Office visit 	100% of Allowable Amount after \$25/\$35 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • All other services 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
35 visits maximum per Calendar Year		
Physical Medicine Services		
<ul style="list-style-type: none"> • Office visit/office services 	100% of Allowable Amount after \$25/\$35 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
<ul style="list-style-type: none"> • All other services in the outpatient setting 	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE PHARMACY BENEFITS

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy 90 day supply with 1 Copayment Amount per 30-day supply at a Participating Pharmacy	\$10 Copayment Amount – Generic Drug \$25 Copayment Amount* – Preferred Brand Name Drug \$40 Copayment Amount* – Non-Preferred Brand Name Drug	80% of Allowable Amount minus Copayment Amount
Specialty Drugs limited to a 30-day supply at a Participating Pharmacy	\$10 Copayment Amount – Generic Drug \$25 Copayment Amount* – Preferred Brand Name Drug \$40 Copayment Amount* – Non-Preferred Brand Name Drug	80% of Allowable Amount minus Copayment Amount
Mail Service Prescription	Mail-Order Pharmacy	
Mail-Order Program One Copayment Amount per 90 day supply, up to a 90-day supply only	\$20 Copayment Amount – Generic Drugs \$50 Copayment Amount* – Preferred Brand Name Drugs \$80 Copayment Amount* – Non-Preferred Brand Name Drugs	Not Covered
Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Select Vaccinations Obtained through Participating Pharmacies**	Select Participating Pharmacy - 100% of Allowable Amount Any other Participating Pharmacy - 80% of Allowable Amount minus Copayment Amount	Not Covered
Pharmacy Deductible	\$100 per Individual each Calendar Year	
Prior Authorization Provision	Applies	
Step Therapy Provision	Applies	
Limitations on Quantities Dispensed	Applies	

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

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

NOTE: In the *How Member Payment is Determined* subsection of the **PHARMACY BENEFITS** section, an explanation of how the prescription drug products are separated into tiers is shown.

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are not eligible for Maternity Care benefits.

Preexisting Conditions

Preexisting conditions are covered immediately.

INTRODUCTION

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

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

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

Managed Health Care - In-Network Benefits

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

If you choose a Network Provider, the Provider will bill the Claim Administrator - not you - for services provided.

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

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

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

Managed Health Care - Out-of-Network Benefits

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

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Co-Share Amounts and Deductibles,
- Limited or non-covered services, and
- Failure to Preauthorize penalty.

Pharmacy Benefits

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

- the Prescription Order is filled at a Participating Pharmacy, or at a non-Participating Pharmacy, or through the mail-order program; or
- a Generic Drug is dispensed; or
- a Preferred or Non-Preferred Brand Name Drug is dispensed; or

- a Specialty Drug is dispensed; or
- your Plan includes a separate Pharmacy Deductible.

Important Contact Information

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

Customer Service Helpline

Customer Service Representatives can:

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

BCBSTX Website

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

Medical Preauthorization Helpline

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

WHO GETS BENEFITS

Eligibility Requirements for Coverage

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

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

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

Employee Eligibility

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

Dependent Eligibility

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

1. Your spouse;
2. A child under the limiting age shown in your Schedule of Coverage;
3. Any other child included as an eligible Dependent under the Plan.

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

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

It is important that your application for coverage under the Plan is received timely by the Claim Administrator through the Plan Administrator.

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

1. Are eligible on the Plan Effective Date and the application is received by the Claim Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; or

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

Effective Dates - Delay of Benefits Provided

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

Effective Dates - Late Enrollee

If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date.

Loss of Other Health Insurance Coverage

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

1. The Employee or Dependent was covered under a Health Benefit Plan, self-funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
 - b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
 - c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective the first day of the Plan Month following receipt of the application by the Claim Administrator through the Plan Administrator.

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

Loss of Governmental Coverage

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

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the Medicaid Program or enrolled in CHIP, and who is a participant in the HIPP Reimbursement Program may enroll with no enrollment period

restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claim Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claim Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Dependent Enrollment Period

1. *Special Enrollment Period for Newborn Children*

Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claim Administrator through the Plan Administrator within 31 days of birth and pay any required contributions within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Claim Administrator is notified through the Plan Administrator after that 31-day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

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

Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Claim Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Claim Administrator through the Plan Administrator after that 31-day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

3. *Court Ordered Dependent Children*

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

4. *Other Dependents*

Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

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

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

Other Employee Enrollment Period

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

If you marry and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse. If the written application is received within 31 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Claim Administrator through the Plan Administrator.

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

Enrollment Application/Change Form

Use this form to...

- Notify the Plan of a change to your name
- Add Dependents
- Drop Dependents
- Cancel all or a portion of your coverage
- Notify the Plan of all changes in address for yourself and your Dependents. An address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area of the Network.

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

Changes In Your Family

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

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

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

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

HOW THE PLAN WORKS

Allowable Amount

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

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

Case Management

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

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

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

Freedom of Choice

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

Identification Card

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

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

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

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

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

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
 - a. Use of the Identification Card prior to your Effective Date;
 - b. Use of the Identification Card after your date of termination of coverage under the Plan;
 - c. Obtaining prescription drugs or other benefits for persons not covered under the Plan;
 - d. Obtaining prescription drugs or other benefits that are not covered under the Plan;
 - e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under the Plan;
 - f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
 - g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of the Plan;
 - h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
 - i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
 - a. Denial of benefits;
 - b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
 - c. Limitation on the use of the Identification Card to one designated Physician, Other Provider, or Participating Pharmacy of your choice;
 - d. Recoupment from you or any of your covered Dependents of any benefit payments made;
 - e. Pre-approval of drug purchases and medical services for all Participants receiving benefits under your coverage;
 - f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

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

ParPlan

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

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

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

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

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

Preexisting Conditions Provision

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

Specialty Care Providers

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

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

- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Use of Non-Contracting Providers

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

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

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

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

The following types of services require Preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Health,
- Home Infusion Therapy,
- Home Hospice,
- Outpatient transplant evaluations,
- Non-emergency Fixed-Wing Air Ambulance transportation,
Please refer to Fixed-Wing Air Ambulance definition in the DEFINITIONS section of this Benefit Booklet.
- Outpatient Procedures/Services:

Ears, Nose and Throat (ENT):

- Bone conduction hearing aids,
- Cochlear implant,
- Nasal and sinus surgery,

Gastroenterology (Stomach):

- Gastric electrical stimulation (GES)

Neurological:

- Deep brain stimulation,
- Sacral nerve neuromodulation/stimulation,
- Vagus nerve stimulation (VNS),

Orthopedic (Musculoskeletal):

- Artificial intervertebral disc,
- Functional neuromuscular electrical stimulation (FNMES),
- Lumbar spinal fusion,
- Orthopedic applications of stem-cell therapy,
- Spinal decompression and fusion surgeries,
- Total disc replacement surgery,
- Pneumatic compression devices – Durable Medical Equipment (DME),

Surgical Procedures:

- Orthognathic Surgery; face reconstruction,
- Mastopexy, breast lift,
- Reduction mammoplasty; breast reduction,

Specialty Pharmacy:

- Medical Benefit Specialty Drugs (Specialty Drugs administered by your provider),

Wound Care:

- Hyperbaric oxygen (HBO2) therapy.

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

- If you transfer to another facility or to or from a specialty unit within the facility.

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

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

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

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

Preauthorization for Inpatient Hospital Admissions

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

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

If the Physician or Provider of services is not a Network Provider then you, your Physician, Provider of services, or a family member should obtain Preauthorization by the Plan by calling one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 6:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned no later than 24 hours after the call is received. We will follow-up with your Provider's office. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

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

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

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

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

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

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

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

Preauthorization for Extended Care Expenses and Home Infusion Therapy

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

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

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

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

Failure to Preauthorize

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy is not obtained:

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

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

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

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

CLAIM FILING AND APPEALS PROCEDURES

Claim Filing Procedures

Filing of Claims Required

Claim Forms

When the Claim Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

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

Who Files Claims

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

Contracting Providers

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

Non-Contracting Providers

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

Mail-Order Program

When you receive Covered Drugs dispensed through the mail-order program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from your Employer, from the Claim Administrator, from the BCBSTX website at www.bcbstx.com, or by calling the Customer Service Helpline.

Participant-Filed Claims

- Medical Claims

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

- Prescription Drug Claims

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

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

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

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

Where to Mail Completed Claim Forms

Medical Claims

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

Prescription Drug Claims

Blue Cross and Blue Shield of Texas
c/o Prime Therapeutics LLC
P. O. Box 25136
Lehigh Valley, PA 18002-5136

Mail-Order Program

Blue Cross and Blue Shield of Texas
c/o AllianceRx Walgreens Prime
P. O. Box 29061
Phoenix, AZ 85038-9061

Who Receives Payment

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

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

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

Benefit Payments to a Managing Conservator

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

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

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

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

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

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claim Administrator within fifteen (15) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claim Administrator

A claim will be considered received by the Claim Administrator for processing upon actual delivery to the Administrative Office of the Claim Administrator in the proper manner and form and with all of the information

required. If the claim is not complete, it may be denied or the Claim Administrator may contact either you or the Provider for the additional information.

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

Review of Claim Determinations

Claim Determinations

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

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

If a Claim Is Denied or Not Paid in Full

On occasion, the Claim Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claim Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision as described in **Claim Appeal Procedures** below.

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

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

How to Appeal an Adverse Benefit Determinations

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

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

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

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

- The Claim Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claim Administrator will give you a written decision within 60 days after it receives your request for review.

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

Preauthorization Prior Authorization Appeal Procedures

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

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

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

Once you have requested this review, you may submit additional information and comments on your claim Preauthorization decision to the Claim Administrator as long as you do so within 30 days of the date you ask for a review. Also, during this 30-day period, you may review any documents relevant to your Preauthorization decision held by the Claim Administrator.

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

Interpretation of Employer's Plan Provisions

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

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

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

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section prior to taking further action under your Health Benefit Plan.

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

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

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

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

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

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

Copayment Amounts

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

A Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a family practitioner, a general practitioner, an obstetrician/gynecologist, a pediatrician, an internist or a Professional Other Provider and defined in the **DEFINITIONS** section of this Benefit Booklet. A Copayment Amount is required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

A different Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a Specialty Care Provider as classified by the American Board of Medical Specialties as a Specialty Care Provider.

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

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

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

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

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

A Copayment Amount, if shown on your Schedule of Coverage, will be required for each visit to a Retail Health Clinic.

Deductibles

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

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

Pharmacy Deductible: The Pharmacy Deductible amount indicated on your Schedule of Coverage must be satisfied by each Participant each Calendar Year before Covered Drug benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

Your Schedule of Coverage indicates “Three-Month Deductible carryover applies.” This means that any Eligible Expenses incurred during the last three months of a Calendar Year and applied toward satisfaction of the “Calendar Year Deductible” for that Calendar Year may be applied toward satisfaction of the Deductible for the following Calendar Year.

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

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

Co-Share Stop-Loss Amount

Most of your Eligible Expense payment obligations are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss Amount maximum.

Your Co-Share Stop-Loss Amount will **not** include:

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

Individual Co-Share Stop-Loss Amount

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

Family Co-Share Stop-Loss Amount

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

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

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

Eligible Expenses applied toward satisfying the “individual” Co-Share Stop-Loss Amount maximum will apply toward both the In-Network and the Out-of-Network “Co-Share Stop-Loss Amount” maximum shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the “family” Co-Share Stop-Loss Amount maximum will apply toward both the In-Network and the Out-of-Network “Co-Share Stop-Loss Amount” maximum shown on your Schedule of Coverage.

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

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

Changes In Benefits

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

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

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

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under “Inpatient Hospital Expenses” on your Schedule of Coverage is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay. This excess amount will be applied to the Co-Share Amounts.

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

Refer to your Schedule of Coverage for information regarding Deductibles, Co-Share percentages, and penalties for failure to Preauthorize that may apply to your coverage.

Medical-Surgical Expenses

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

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

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

Medical-Surgical Expense shall include:

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

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

7. For Emergency Care, professional local ground ambulance transportation or air ambulance transportation to the nearest Hospital appropriately equipped and staffed for treatment of the Participant’s condition. Non-Emergency ground ambulance transportation from one acute care Hospital to another acute care Hospital for diagnostic or therapeutic services (e.g., MRI, CT scans, acute interventional cardiology, intensive care unit services, etc.) may be considered Medically Necessary when specific criteria are met. The non-emergency ground ambulance transportation to or from a hospital or medical facility, outside of the acute care hospital setting, may be considered Medically Necessary when the Participant’s condition is such that trained ambulance

attendants are required to monitor the Participant's clinical status (e.g., vital signs and oxygenation), or provide treatment such as oxygen, intravenous fluids or medications, in order to safely transport the Participant, or the Participant is confined to bed and cannot be safely transported by any other means. Non-Emergency ground ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.

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

8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
13. Home Infusion Therapy.
14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or scheduled services in the outpatient treatment room of a Hospital.
15. Certain Diagnostic Procedures.
16. Outpatient Contraceptive Services and prescription contraceptive devices. NOTE: Prescription oral contraceptive medications are covered under the **PHARMACY BENEFITS** portion of your Plan.
17. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.
18. Drugs that have not been approved by the FDA for self-administration when injected, ingested or applied in a Physician's or Professional Other Provider's office.
19. Elective Abortions.
20. Elective Sterilizations.

Extended Care Expenses

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

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

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

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

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

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

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

Services and supplies for Extended Care Expenses:

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

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

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

3. For Hospice Care:

Home Hospice Care:

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

Facility Hospice Care:

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

Special Provisions Expenses

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

Benefits for Treatment of Complications of Pregnancy

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

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent children will not be eligible for Maternity Care benefits.

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

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

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

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

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for Emergency Care medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings. Services provided in an emergency room, freestanding emergency room, or other comparable facility that are not Emergency Care may be excluded from Emergency Care coverage, although these services may be covered under another benefit, if applicable.

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

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

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

All treatment received following the onset of an accidental injury or emergency care will be eligible for In-Network Benefits. For a non-emergency, In-Network Benefits will be available only if you use Network Providers. For a non-emergency, if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. A Copayment Amount, in the amount indicated on your Schedule of Coverage, will be required for each Urgent Care visit. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or

unscheduled, walk-in care outside of a hospital emergency room/treatment room department or physician's office. The necessary medical care is for a condition that is not life-threatening.

Benefits for Retail Health Clinics

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

Benefits for Speech and Hearing Services

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

Benefits for Screening Tests for Hearing Impairment

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

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

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

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

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

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

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

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by Accidental Injury, and such injury resulting from domestic violence or a medical condition, to healthy, un-restored natural teeth and supporting tissues. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

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

Benefits for Organ and Tissue Transplants

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

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

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

Benefits will be available for:

- a. A recipient who is covered under this Plan; and
 - b. A donor who is a Participant under this Plan; and
3. Covered services and supplies include services and supplies provided for the:
 - a. Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
 - b. Donor search and acceptability testing of potential live donors; and
 - c. Removal of organs or tissues from living or deceased donors; and
 - d. Transportation and short-term storage of donated organs or tissues.
 4. No benefits are available for a Participant for the following services or supplies:
 - a. Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
 - b. Living and/or travel expenses of the recipient or a live donor;
 - c. Purchase of the organ or tissue; or
 - d. Organs or tissue (xenograft) obtained from another species.
 5. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this Benefit Booklet for more specific information about Preauthorization.
 - a. Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
 - b. At the time of Preauthorization, the Claim Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claim Administrator determines that an extension is Medically Necessary.
 6. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claim Administrator considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an Acquired Brain Injury:

- Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include

interviews of the individual, family, or others;

- Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior;
- Neurophysiological testing - An evaluation of the functions of the nervous system;
- Neurophysiological treatment - Interventions that focus on the functions of the nervous system;
- Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation - The process(es) of restoring or improving a specific function.

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

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

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

Benefits for Treatment of Diabetes

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

1. *Diabetes Equipment*

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

2. *Diabetes Supplies*

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

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

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

Initial and follow-up instruction concerning:

- a. The physical cause and process of diabetes;
- b. Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
- c. Prevention and treatment of special health problems for the diabetic patient;
- d. Adjustment to lifestyle modifications; and
- e. Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

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

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

Benefits for Physical Medicine Services

Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

Benefits for Chiropractic Services

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

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

Benefits for Certain Tests for Detection of Prostate Cancer

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

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

Benefits for Routine Exams and Immunizations

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

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

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

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

Benefits for Mammography Screening

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

Benefits for Detection and Prevention of Osteoporosis

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

Qualified Individual means:

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

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer, include:

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

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

Benefits will be provided for outpatient facilities and anesthesia charges at the applicable Co-Share Amount after the Deductible as shown on your Schedule of Coverage

Benefits will be provided for Physician services when billed with a medical diagnosis at the applicable Co-Share Amount after the Deductible.

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

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

Benefits for Childhood Immunizations

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

Benefits are available for:

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

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

MEDICAL LIMITATIONS AND EXCLUSIONS

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

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claim Administrator.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
 - As a result of war, declared or undeclared, or any act of war; or
 - While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges:
 - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
 - For completion of any insurance forms; or
 - For acquisition of medical records.
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
 - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claim Administrator; or
 - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**.
13. Any services or supplies provided for Custodial Care.
14. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.

15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
17. Any services or supplies provided for:
 - Treatment of myopia and other errors of refraction, including refractive surgery; or
 - Orthoptics or visual training; or
 - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
 - Examinations for the prescription or fitting of eyeglasses or contact lenses, except as may be provided under the ***Benefits for Routine Exams and Immunizations*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet; or
 - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the ***Benefits for Speech and Hearing Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
18. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the ***Benefits for Physical Medicine Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.
19. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.
20. Any services or supplies provided primarily for:
 - Environmental Sensitivity;
 - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
 - Inpatient allergy testing or treatment.
21. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
22. Any services or supplies provided for, in preparation for, or in conjunction with:
 - Sterilization reversal (male or female);
 - Sexual dysfunctions;
 - In vitro fertilization; and
 - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.
23. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.
24. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
25. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
26. Services or supplies for smoking cessation programs and the treatment of nicotine addiction.

27. Any services or supplies provided for the following treatment modalities:
- acupuncture;
 - intersegmental traction;
 - surface EMGs;
 - spinal manipulation under anesthesia; and
 - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
28. Any services or supplies furnished under the In-Network or Out-of-Network portions of the Plan by a Contracting Facility for which such facility had not been specifically approved to furnish under a written contract or agreement with the Claim Administrator will be paid at the Out-of-Network benefit level.
29. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased “over the counter” for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.
30. NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.
31. Any benefits in excess of any specified dollar, day/visit, or Calendar Year maximums.
32. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
33. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
34. Replacement Prosthetic Appliances when it is necessitated by misuse or loss by the Participant.
35. Private duty nursing services.
36. Any Covered Drugs for which benefits are available under the Pharmacy Benefits portion of the Plan.
37. Any outpatient prescription or nonprescription drugs.
38. Self-administered drugs dispensed or administered by a Physician in his/her office.
39. Any services or supplies for Mental Health Care.
40. Any services or supplies for treatment of Serious Mental Illness.
41. Any services or supplies for treatment of Substance Use Disorder.
42. Any services or supplies provided for reduction mammoplasty.
43. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
44. Any services or supplies provided for the following:
- Cognitive rehabilitation therapy - *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual’s brain-behavioral deficits;
 - Cognitive communication therapy - *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
 - Neurocognitive rehabilitation - *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
 - Neurocognitive therapy - *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;

- Neurofeedback therapy - *Services* that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Post-acute transition services - *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration; and
- Community reintegration services - *Services* that facilitate the continuum of care as an affected individual transitions into the community.

45. Biofeedback or other behavior modification services.

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

- ***For multiple surgeries*** - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

- **For procedures, services, or supplies provided to Medicare recipients** - The Allowable Amount will not exceed Medicare's limiting charge.
- **For Covered Drugs as applied to Participating and non-Participating Pharmacies** - The Allowable Amount for Participating Pharmacies and the mail-order program will be based on the provisions of the contract between the Claim Administrator and the Participating Pharmacy or Pharmacy for the mail-order program in effect on the date of service. The Allowable Amount for non-Participating Pharmacies will be based on the Average Wholesale Price.

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

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

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

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

Certain Diagnostic Procedures means:

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

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

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

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

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

Complications of Pregnancy means:

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

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

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

Co-Share Amount means the dollar amount of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan. Refer to **Co-Share Stop-Loss Amount** in **ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS** of the Benefit Booklet for additional information.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

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

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
3. Removal of complete/partial bony impacted teeth;
4. Incision and drainage of facial abscess; and
5. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

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

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

Dependent means your spouse as defined by applicable law or any *child* covered under the Plan who is:

1. Under the Dependent child limiting age shown on your Schedule of Coverage;
2. A *child* of any age who is medically certified as disabled and dependent on the parent for support and maintenance.

Child means:

- a. Your natural child; or
- b. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or
- c. Your stepchild; or
- d. An eligible foster child; or

e. A child not listed above:

- (1) whose primary residence is your household; and
- (2) to whom you are legal guardian or related by blood or marriage; and
- (3) who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

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

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

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

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

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

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

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

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

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

Employee means a person who:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
 - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
 - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

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

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

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

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

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

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

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

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

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

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

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

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;
3. Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse; and

5. Has in effect a Hospital Utilization Review Plan.

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

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

Identification Card means the card issued to the Employee by the Claim Administrator of the Plan indicating pertinent information applicable to his coverage.

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

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

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

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

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

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

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.
2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

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

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

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

1. The individual:
 - a. Was covered under another Health Benefit Plan or self-funded Health Benefit Plan at the time the individual was eligible to enroll; and
 - b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self-funded Health Benefit Plan was the reason for declining enrollment; and
 - c. Has lost coverage under another Health Benefit Plan or self-funded Health Benefit Plan as a result of:
 - (1) termination of employment;
 - (2) reduction in the number of hours of employment;
 - (3) termination of the other plan's coverage;
 - (4) termination of contributions toward the premium made by the Employer;
 - (5) COBRA coverage has been exhausted;
 - (6) cessation of Dependent status;
 - (7) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
 - (8) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and
 - d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self-funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.
2. The request for enrollment is made by the individual within the 60th day after the date on which coverage under Medicaid or CHIP terminates.
3. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
4. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
5. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.
6. A Dependent child is not a Late Enrollee if the child:
 - a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
 - b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
 - c. The child has lost coverage under Medicaid or CHIP; and
 - d. The request for enrollment is made within the 60th day after the date on which coverage under Medicaid or CHIP terminates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. **Facility Other Provider** - an institution or entity, only as listed:
 - a. Durable Medical Equipment Provider
 - b. Home Health Agency
 - c. Home Infusion Therapy Provider
 - d. Hospice
 - e. Imaging Center
 - f. Independent Laboratory
 - g. Prosthetics/Orthotics Provider
 - h. Renal Dialysis Center
 - i. Skilled Nursing Facility
 - j. Therapeutic Center
2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
 - a. Advanced Practice Nurse
 - b. Doctor of Chiropractic
 - c. Doctor of Dentistry
 - d. Doctor of Optometry
 - e. Doctor of Podiatry
 - f. Doctor in Psychology
 - g. Licensed Acupuncturist
 - h. Licensed Audiologist
 - i. Licensed Dietitian
 - j. Licensed Hearing Instrument Fitter and Dispenser
 - k. Licensed Marriage and Family Therapist
 - l. Licensed Occupational Therapist
 - m. Licensed Physical Therapist
 - n. Licensed Speech-Language Pathologist
 - o. Licensed Surgical Assistant
 - p. Nurse First Assistant
 - q. Physician Assistant

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

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

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

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

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

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

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

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

Plan Administrator means a named administrator of the Group Health Plan (GHP) having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

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

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

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

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

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

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

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

Proof of Loss means written evidence of a claim including:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PHARMACY BENEFITS

Covered Drugs

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

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

As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits.

Injectable Drugs

Injectable drugs approved by the FDA for self-administration are covered under the Plan.

Select Vaccinations Obtained through Participating Pharmacies

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

Please note that each Pharmacy that provides this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance.

Childhood immunizations subject to state regulations are not available under these Pharmacy Benefits. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases

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

Specialty Drugs

Benefits are available for Specialty Drugs. Specialty Drugs are generally prescribed to treat a chronic complex medical condition. They often require careful adherence to treatment plans and have special handling and storage requirements.

Retin A or Pharmacologically Similar Topical Drugs

Retin A or pharmacologically similar topical drugs are covered.

Selecting a Pharmacy

Participating Pharmacy

When you go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log,
- pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

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

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

You may be required to pay for limited or non-covered services. No claim forms are required.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at www.bcbstx.com or contact the Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

Non-Participating Pharmacy

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

- the Co-Share Amount indicated on your Schedule of Coverage,
- less the Pharmacy Deductible,
- less the appropriate Copayment Amount, and
- less any pricing differences that may apply to the Covered Drug you receive.

Mail-Order Program

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

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

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

Specialty Pharmacy Program

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

The Specialty Pharmacy Program delivery service offers:

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

If you and your covered Dependents use the Specialty Pharmacy Program, you should contact Customer Service at the toll-free number shown in this Benefit Booklet or on your Identification Card for information about how to submit your Prescription Orders. You will also be given information on how to make payment for your share of the cost (see **Your Cost** below).

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

Your Cost

Pharmacy Deductible

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

The individual Deductible amount shown under “Pharmacy Deductible” on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. After the Pharmacy Deductible is met, the Participant will pay the appropriate Copayment Amount and any pricing difference that may apply to the Covered Drug you receive.

Whether you use a Participating Pharmacy, a non-Participating Pharmacy, through the mail service pharmacy, the Allowable Amount of your Covered Drug expenses will be applied toward satisfaction of your Pharmacy Deductible.

If you use a Participating Pharmacy, the pharmacist can tell you once the Pharmacy Deductible has been satisfied or you may contact the Customer Service Helpline for this information. If you intend to use a Non-Participating Pharmacy, you should contact the Customer Service Helpline prior to going to the Pharmacy to determine if your Pharmacy Deductible has been satisfied since non-Participating Pharmacies cannot access this information online.

Copayment Amounts

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

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

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

How Copayment Amounts Apply

When your authorized Health Care Practitioner has marked the Prescription Order “Brand Necessary” or “Brand Medically Necessary,” the pharmacist may *only* dispense the Brand Name Drug and you pay the appropriate Brand Name Drug Copayment Amount.

If the authorized Health Care Practitioner has not stipulated a dispensing directive prohibiting substitution of a generic equivalent, you may still choose to buy the Brand Name Drug instead of the Generic Drug.

If the Brand Name Drug dispensed is on the Drug List, your payment amount will be the sum of:

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

If the Brand Name Drug dispensed is a Non-Preferred Brand Name Drug, your payment amount will be the sum of:

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

How Member Payment is Determined

Prescription drug products are separated into tiers. Generally, each drug is placed into one of three drug tiers:

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

Any Deductible, Copayment Amount or Co-Share Amount for Covered Drugs on each drug tier is shown on your Schedule of Coverage. You can also contact customer service at the toll-free number on your Identification Card.

About Your Benefits

Drug List

The Drug List is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other Pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.

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

Day Supply

Benefits for Covered Drugs obtained from a Participating Pharmacy, a non-Participating Pharmacy, or through the mail-order program are provided up to the maximum day supply limit as indicated on your Schedule of Coverage. The Copayment Amount applicable for the designated day supply of dispensed drugs are also indicated on your Schedule of Coverage. The Claim Administrator has the right to determine the day supply. Payment for benefits covered under this Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

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

Dispensing Quantity Versus Time Limits

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

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

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

or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

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

Step Therapy

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

When you submit a Prescription Order to a Participating Pharmacy or through the mail service prescription drug program 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 that has not been previously tried. A list of step therapy medications are available to you and your Health Care Practitioner on our website at www.bcbstx.com.

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

Prior Authorizations

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

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

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

Controlled Substances Limitations

In the event that BCBSTX determines that a Participant may be receiving quantities of a Controlled Substance not supported by FDA approved dosages or recognized treatment safety or guidelines, any additional drugs may be subject to a review for Medical Necessity, appropriateness and other coverage restrictions which may include but not limited to limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the Controlled Substance and/or limiting coverage to certain quantities. Additional Copayment Amounts, Co-Share Amounts and any Deductible may apply.

Right of Appeal

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

Limitations and Exclusions

Pharmacy benefits are not available for:

1. Drugs which do not by law require a Prescription Order from a Provider or authorized Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.
2. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary), including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.
3. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order) such as, but not limited to therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections shall be specific exceptions to this exclusion).
4. Administration or injection of any drugs.
5. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
6. Drugs injected, ingested or applied in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
7. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
8. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
9. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select Vaccinations administered through Participating Pharmacies are an exception to this exclusion.
10. Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.
11. Contraceptive devices, non-prescription contraceptive materials, (**except** prescription contraceptive drugs which are Legend Drugs.) NOTE: Coverage for contraceptive devices is provided under the medical portion of this Plan.
12. Oral and injectable infertility and fertility medications.
13. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, except as required by the Affordable Care Act.
14. Drugs required by law to be labeled: "Caution - Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.

15. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your Schedule of Coverage, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
16. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
17. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exclusion does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
18. Any drugs or supplies provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
19. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
20. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
21. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.
22. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
23. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.
24. Compounded drugs that do not meet the definition of Compound Medications in this portion of your Benefit Booklet.
25. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
26. Athletic performance enhancement drugs.
27. Bulk powders.
28. Surgical supplies.
29. Ostomy products.
30. Diagnostic agents. This exclusion does not apply to diabetic test strips.
31. Drugs used for general anesthesia.
32. Allergy serum and allergy testing materials.
33. Injectable drugs, except self-administered Specialty Drugs or those approved by the FDA for self-administration.
34. Self-administered drugs dispensed or administered by a Physician in his/her office.
35. Some drugs are manufactured under multiple names and have many therapeutic equivalents. In such cases, BCBSTX may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under your Plan, the drug purchased will not be covered under any benefit level.
36. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.

37. Shipping, handling or delivery charges.
38. Institutional packs and drugs that are repackaged by anyone other than the original manufacturer.
39. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.
40. Depo-Provera (IM injectable).
41. Brand proton pump inhibitors.
42. Drugs determined by the Plan to have inferior efficacy or significant safety issues.
43. Drugs in a drug class where is an over the counter alternative available.
44. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

Definitions

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

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

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

Brand Name Drug means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from generic to 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 Amount obligations from generic to brand name.

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

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

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 Amount means the paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy.

Covered Drugs means any Legend Drug (including insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, with disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by an authorized Health Care Practitioner naming a Participant as the recipient;
2. For which a written or verbal Prescription Order is provided by an authorized Health Care Practitioner;
3. For which a separate charge is customarily made;
4. Which is not consumed at the time and place that the Prescription Order is written;

5. For which the U.S. Food and Drug Administration (FDA) has given approval for at least one indication; and
6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

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

Drug List means a list of drugs that may be covered under the **PHARMACY BENEFITS** portion of the Plan. This 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. Changes to this list will be implemented on the Employer's Contract Anniversary Date. The Drug List and any modifications will be made available to Participants.

Generic Drug means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs, BCBSTX utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. You should know that not all drugs identified as a "generic" by the drug product database, manufacturer, Pharmacy, or your Health Care Practitioner will adjudicate as generic by BCBSTX. Generic Drugs are shown on the Drug List which is available by accessing the BCBSTX website at www.bcbstx.com. You may also contact the Customer Service Helpline number shown on your Identification Card for more information.

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

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

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

Non-Preferred Brand Name Drug means a Brand Name Drug that does not appear on the Basic Drug List. Drugs that do not appear on the Basic Drug List are subject to the Non-Preferred Brand Name Drug Copayment/Co-Share. The Basic Drug List is available by accessing the website at www.bcbstx.com.

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

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty drug Pharmacy which has entered into an agreement to provide pharmaceutical services to Participants under the Plan. A retail Participating Pharmacy may or may not be a **Select Participating Pharmacy** as that term is used in the *Select Vaccinations Obtained through Participating Pharmacies* section above.

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

Pharmacy Vaccine Network means the network of select Participating Pharmacies which have a written agreement with BCBSTX to provide certain vaccinations to Participants under this Plan.

Preferred Brand Name Drug means a Brand Name Drug that is identified on the Basic Drug List. The Basic Drug List is available by accessing the website at www.bcbstx.com.

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

Select Participating Pharmacy means a Pharmacy that has specifically contracted with BCBSTX to administer vaccinations to Participants. Not all Participating Pharmacies are Select Participating Pharmacies.

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

1. used in limited patient populations or indications,
2. typically self-injected,
3. limited availability, requires special dispensing, or delivery and/or patient support is required and therefore, they are difficult to obtain via traditional pharmacy channels, and/or
4. complex reimbursement procedures are required.

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

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claim Administrator.

Amendments

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

Assignment and Payment of Benefits

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

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

Claims Liability

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

Disclosure Authorization

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

Medicare

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

Participant/Provider Relationship

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

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

Refund of Benefit Payments

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

Rescission

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

Subrogation/Reimbursement

Accepting benefits under this Plan automatically assigns to the Plan any rights you or your Dependents may have to recovery from any third party related to such benefits up to the full amount of such benefits.

Right of Subrogation

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

Right of Reimbursement

The Plan also has a right of reimbursement. That means that when you or your Dependent recover through judgement, settlement, or otherwise from any person, organization, or insurer, you or your Dependent must reimburse the Plan for the amount of benefits the Plan has paid or provided.

You and your Dependents agree to hold recoveries in a constructive trust for the benefit of the Plan. The Plan has an equitable lien on any amount of the recovery.

Right to Recovery by Subrogation or Reimbursement

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

The Plan shall have no obligation to pay medical benefits to you and your Dependents if you or your Dependents refuse to cooperate with the Plan's subrogation and refund rights or refuse to execute and deliver such papers as the Plan may require in furtherance of its subrogation and reimbursement rights.

Coordination of Benefits

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

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

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:
 - a. group or blanket insurance;
 - b. franchise insurance that terminates upon cessation of employment;
 - c. group hospital or medical service plans and other group prepayment coverage;

- d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements; or
- e. governmental plans, or coverage required or provided by law.

Plan does not include:

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

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

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

3. **Primary Plan/Secondary Plan**

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

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

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

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

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

Order of Benefit Determination Rules

1. **General Information**

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

2. **Rules**

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

- a. **Non-Dependent/Dependent.** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
 - (1) secondary to the Plan covering the Participant as a Dependent and
 - (2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

- b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:
- (1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
 - (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.
- However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.
- c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:
- (1) First, the Plan of the parent with custody of the child;
 - (2) Then, the Plan of the spouse of the parent with custody, if applicable;
 - (3) Finally, the Plan of the parent not having custody of the child.
- However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.
- e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.
- f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:
- (1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);
 - (2) Second, the benefits under the continuation coverage.
- If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.
- g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. When This Section Applies

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

2. Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

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

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

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

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

Right to Receive and Release Needed Information

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

Facility of Payment

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

Right to Recovery

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

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

Termination of Coverage

Termination of Individual Coverage

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

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

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

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

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

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

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

Administrator to the Claim Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled Dependent* beyond the limiting age, the Claim Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Termination of the Group

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

Continuation of Group Coverage - Federal

COBRA Continuation - Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Minimum Size of Group

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

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty-six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,
2. death of the covered Employee,
3. the covered Employee becomes eligible for Medicare, or
4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.
2. The last day of the thirty-six (36) month period for events which have a maximum continuation period of thirty-six (36) months.
3. The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.
4. The Group Health Plan is canceled.
5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.
6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

Information Concerning Employee Retirement Income Security Act of 1974 (ERISA)

If the Health Benefit Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. The Claim Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claim Administrator will send any information which the Claim Administrator has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this Benefit Booklet.
4. BCBSTX, as the Claim Administrator is not the ERISA “Plan Administrator” for benefits or activities pertaining to the Health Benefit Plan.
5. The Plan Administrator has given the Claim Administrator the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determinations. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan’s provisions and determining questions of eligibility and benefits. Any decisions made by the Plan Administrator shall be final and conclusive.

AMENDMENTS

NOTICES

NOTICE

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

Out-of-Area Services

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

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

A. BlueCard® Program

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

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

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

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

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

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

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

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

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

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

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1. In General

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

2. Exceptions

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

- a. the amount calculated using the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area (and described in Section C(a)(1) above); or
- b. The following:
 1. for professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area; or an amount based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or
 2. for Hospital or facility Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area; or an amount based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

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

D. Value-Based Programs BlueCard® Program

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

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

E. Blue Cross Blue Shield Global Core Program

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

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

- **Inpatient Services**

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

- **Outpatient Services**

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

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

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

NOTICE

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

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

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

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

NOTICE

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

NOTICE

This group health plan believes this plan is a “grandfathered health plan” under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or the Plan Administrator.

If your group health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

Information Provided by your Employer

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2019. Contact your State for more information on eligibility -

ALABAMA - Medicaid	FLORIDA - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA - Medicaid	GEORGIA - Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: Medicaid www.medicaid.georgia.gov - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS - Medicaid	INDIANA - Medicaid

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA - Medicaid	KANSAS - Medicaid
Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY - Medicaid	NEW HAMPSHIRE - Medicaid
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Website: https://www.dhhs.nh.gov/oi/hipp.htm Phone: 603-271-5218 Toll-Free: 1-800-852-3345, ext 5218
LOUISIANA - Medicaid	NEW JERSEY - Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE - Medicaid	NEW YORK - Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS - Medicaid and CHIP	NORTH CAROLINA - Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MINNESOTA - Medicaid	NORTH DAKOTA - Medicaid
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739 or 651-431-2670	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI - Medicaid	OKLAHOMA - Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA - Medicaid	OREGON - Medicaid and CHIP
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEBRASKA - Medicaid	PENNSYLVANIA - Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEVADA - Medicaid	RHODE ISLAND - Medicaid
Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347

<p align="center">SOUTH CAROLINA - Medicaid</p> <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p align="center">VIRGINIA - Medicaid and CHIP</p> <p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p>
<p align="center">SOUTH DAKOTA - Medicaid</p> <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>	<p align="center">WASHINGTON - Medicaid</p> <p>Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473</p>
<p align="center">TEXAS - Medicaid</p> <p>Website: http://gethipptexas.com/ Phone: 1-800-440-0493</p>	<p align="center">WEST VIRGINIA - Medicaid</p> <p>Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)</p>
<p align="center">UTAH - Medicaid and CHIP</p> <p>Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669</p>	<p align="center">WISCONSIN - Medicaid and CHIP</p> <p>Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002</p>
<p align="center">VERMONT - Medicaid</p> <p>Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427</p>	<p align="center">WYOMING - Medicaid</p> <p>Website: https://health.wyo.gov/healthcarefin/medicaid/ Phone: 307-777-7531</p>

To see if any other states have added a premium assistance program since January 31, 2019, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Benefits Security Administration
www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Employee
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2019)

SPECIAL ENROLLMENT NOTICE IF YOU ARE WAIVING GROUP HEALTH INSURANCE

Waiving Coverage Because of Other Health Insurance

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). Also, effective April 1, 2009, Childrens Health Insurance Program Reauthorization Act (CHIPRA) adds two new special enrollment events to HIPAA's special enrollment period rules. Specifically, CHIPRA provides that a group health plan is required to permit an employee who is eligible, but not enrolled, for coverage under the group health plan (or a dependent of the employee if the dependent is eligible, but not enrolled, for coverage) to enroll for coverage under the plan in either of the following circumstances:

- (i) the employee or dependent is covered under Medicaid or a state's Childrens Health Insurance Program (CHIP) and coverage of the employee or dependent under the Medicaid or CHIP plan is terminated as a result of a loss of eligibility for such coverage, and the employee requests coverage under the group health plan within 60 days of the loss of coverage; or**
- (ii) the employee or dependent becomes eligible for a premium assistance subsidy with respect to coverage under the group health plan, and the employee requests coverage under the group health plan within 60 days after the date the employee or dependent is determined to be eligible for the premium assistance subsidy.**

Note that employees have a 60 day period to enroll for coverage under these two new special enrollment events, instead of the shorter 30 day period that group health plans are allowed to impose under HIPAA's existing special enrollment event rules.

Conditions of Special Enrollment

- A. If the other coverage was COBRA coverage, then the COBRA coverage must be exhausted for the special enrollment to apply.
- B. If the other coverage was not COBRA coverage, then the other coverage must terminate because of one of the following reasons:
 - 1. Employer Contributions Towards The Coverage Have Been Terminated, or
 - 2. Loss of Eligibility Under the Other Coverage (divorce, termination of employment, reduction in number of work hours, or death). Loss of

eligibility does not include: 1. Loss of coverage due to failure on the individuals part to pay premiums on a timely basis, or 2. Termination of coverage for cause, such as fraudulent claims and/or intentional misrepresentation of a material fact in connection with the plan

Waiving Coverage But No Other Health Insurance

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator.

**EMPLOYEE RETIREMENT INCOME SECURITY
ACT OF 1974
PLAN ADMINISTRATION INFORMATION**

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your benefit booklet/Certificate. Your Plan Administrator has determined that this information together with the information contained in your benefit booklet/Certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Blue Cross and Blue Shield is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

Name of Plan: Whirlwind Steel Buildings, Inc.

Plan Sponsor: Whirlwind Steel Buildings, Inc. , 8234 Hansen Road, Houston, Tx 77074

Employer Identification Number: 76-0366138

Plan Administrator:

Whirlwind Steel Buildings, Inc., 8234 Hansen Road, Houston, Tx 77074

Plan Number: 501

Claim Administration:

Claims for benefits should be directed to: Blue Cross
and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044901

Type of Plan Administration:

The processing of claims for benefits under the terms of the Plan is provided through a company contracted by the employer and shall hereinafter be referred to as the claims processor.

Agent For Service of Legal Process:

Whirlwind Steel Buildings, Inc.

Collective Bargaining Agreements:

N/A

Trustees of the Plan: N/A

Employees Participating in Section 125:

In addition to the family status events described under the section entitled “Changing From Individual To Family Coverage or Adding Dependents to Family Coverage” in the ELIGIBILITY SECTION of this Certificate or benefit booklet, any one of the following events can also apply under Section 125:

- a. An annulment;
- b. An event that changes your employment status or that of your spouse or your dependent. These events include, but are not limited to, a) termination or commencement of employment; b) a strike or lockout; c) commencement of or a return from an unpaid leave of absence; or d) a change in worksite;
- c. Your dependent has satisfied or ceases to satisfy eligibility requirements for coverage on account of attainment of age, student status or any similar circumstance;
- d. A change in your place of residence or that of your spouse or dependent;
- e. The commencement or termination of an adoption proceeding.

Plan Year: Beginning January 1 and ending December 31

Open Enrollment: The month of December

Funding Arrangements: Contributions for Plan expenses are obtained from the employer and from the covered employees. The employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the employer and the amount to be contributed by the covered employees. The employer pays Plan benefits and administration expenses directly from general assets.

Contributions received from covered persons are used to cover Plan costs and are expended immediately. Excess Loss coverage (Stop Loss Insurance or Reinsurance) has been

obtained.

Benefits and Administration: The Plan provides Hospital, Medical and Surgical benefits as described as described in this booklet. Replacements for lost misplaced copies may be obtained by writing to the Plan Administrator. Notification will be given of changes in benefits that may occur from time to time.

Loss of Benefits: The provisions regarding termination of coverage and limitations and exclusions of benefits which may result in a reduction or loss of benefits are explained in this booklet.

Type of Plan:

Medical Welfare Benefit Plan

Termination of Plan or Bankruptcy: Your employer shall inform you if the Plan should terminate or file for bankruptcy protection.

How To Get Your Benefits:

This information is explained in the section of the booklet entitled “**CLAIMS FILING PROCEDURES.**”

Claim Review Procedure:

This information is explained in the section of the booklet entitled “**REVIEW OF CLAIMS DETERMINATIONS**”

Statement of ERISA Rights:

As a participant in this plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

- a. Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series)

and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- c. Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage:

- a. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this booklet and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

- b. Reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a preexisting exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit under the plan or exercising your rights under ERISA.

Enforce Your Rights:

If your Claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen the plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your Claim is frivolous.

Assistance With Your Questions:

If you have any questions about the plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

Group health plans and health insurance issuers, under USERRA, must protect all persons who perform duty, voluntarily or involuntarily, in the “uniformed services”, which include the Army, Navy, Marine Corps, Air Force, Coast Guard and Public Health Service commissioned corps, as well as the reserve components of each of these services. If you are a pre-service member returning from a period of service in the uniformed services, you are entitled to reemployment from your Employer if you meet the following criteria:

- you held the job prior to service;
- you gave notice to your Employer that you were leaving your employment for service in the uniformed services, unless giving notice was precluded by military necessity or otherwise impossible or unreasonable;
- your cumulative period of service did not exceed five years;
- you were not released from service under dishonorable or other punitive conditions; and
- you reported back to the job in a timely manner or submitted a timely application for reemployment.

The time limits for returning to work are as follows:

- For less than 31 days of service – by the beginning of the first regularly scheduled work period after the end of the calendar day of duty, plus time required to return home safely and an eight hour rest period. If this is impossible or unreasonable through no fault of your own, then as soon as possible;
- For 31 to 180 days of service – you must apply for reemployment no later than **14 days after completion of military service. If this is impossible or unreasonable through no fault of your own, then as soon as possible;**

- For 181 days or more of service – you must apply for reemployment no later than 90 days after completion of military service;
- For service-connected injury or illness – reporting or application deadlines are extended for up to two years if you are hospitalized or convalescing.

Aviso Importante:

Para obtener informacion o para someter una queja usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Texas para informacion o para someter una queja al: 1-800-521-2227. Usted tambien puede escribir a Blue Cross and Blue Shield of Texas al: P. O. Box 660044, Dallas, Texas 75266-0044.

FAMILY AND MEDICAL LEAVE ACT OF 1993

Coverage

If you are covered under the Plan and are eligible for an unpaid family or medical leave of absence as provided under the Family and Medical Leave Act of 1993 (FMLA), you may continue to be covered during such leave for a period of up to twelve (12) weeks in any twelve (12)-consecutive month period. The FMLA requires the Employer to maintain health coverage for a covered employee during a period of eligible leave at the same level and under the same conditions coverage would have been provided if the employee had remained a member of the eligible group and covered under the Plan.

Coverage will be continued during a FMLA leave at the same level and under the same conditions that coverage would have been provided if you had remained a member of the eligible group and covered under the Plan. Such continuation may be combined with any time allowed under the Extension of Coverage section of the Plan for coverage continuation in the event of a leave of absence or disability. If the Employer provides a new health care plan of benefits, or changes health benefits or plans while you are on leave, you are entitled to the new or changed plan or benefits to the same extent as if you were not on leave. You will not be subject to the waiting period or the Pre-Existing Condition limitation when restored to active service with the Employer regardless of whether or not you chose to retain health coverage during FMLA leave. The Employer reserves the right to deny restoration to certain highly compensated or key employees as determined by the FMLA.

Contributions

You must continue to make any required contribution to the Plan in order for coverage to continue. The Employer's obligation to maintain health coverage under FMLA leave will cease if your contribution is more than thirty (30) days overdue. Failure to make the required contribution to the Plan will terminate coverage at the end of the period for which you made the last required contribution.

Further, failure to return from FMLA leave for reasons other than the continuation, recurrence, or onset of a serious health condition that entitles you to leave under FMLA, or other circumstances beyond your control, may result in the recovery, by the Employer, of any contributions made by the Employer toward the continuation of your coverage. When you fail to return from FMLA leave because of the continuation, recurrence, or onset of a serious health condition, thereby precluding the Employer from recovering any contribution made toward continuation of coverage, the Employer may require a certification letter issued by your health care provider or the health care provider of your son, daughter, spouse or parent, as appropriate, verifying the medical necessity for continued leave. The

certification letter must be submitted within thirty (30) days after the Employer's request.

The amount that the Employer may recover is limited to only the Employer's share of allowable contributions as would be calculated under COBRA Continuation of Benefits excluding the two (2) percent fee for administrative costs. The *Employer* may not recover any contributions for any period of FMLA leave covered by paid leave. The employee who returns to active service for at least thirty (30) calendar days is considered to have "returned to work."

Military Family Leave Entitlements

The National Defense Authorization Act for 2008 (NDAA), Public Law 110-181, amended the FMLA to allow eligible employees to take up to 12 weeks of job-protected leave in the applicable 12-month period for any "qualifying exigency" arising out of the active duty or call to active duty status of a spouse, son, daughter, or parent. The NDAA also amended the FMLA to allow eligible employees to take up to 26 weeks of job-protected leave in a "single 12-month period" to care for a covered servicemember with a serious injury or illness.

Military Caregiver Leave grants an eligible employee who is a spouse, son, daughter, parent, or next of kin of a covered servicemember with a serious injury or illness up to a total of **26 workweeks** of **unpaid** leave during a "single 12-month period" to care for the servicemember. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. A serious injury or illness is one that was incurred by a servicemember in the line of duty on active duty that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating. The "single 12-month period" for leave to care for a covered servicemember with a serious injury or illness begins on the first day the employee takes leave for this reason and ends 12 months later, regardless of the 12 month period established by the employer for other types of FMLA leave. An eligible employee is limited to a **combined** total of 26 workweeks of leave for any FMLA-qualifying reason during the "single 12-month period." (Only 12 of the 26 weeks total may be for a FMLA-qualifying reason other than to care for a covered servicemember.)

Qualifying Exigency Leave grants an eligible employee up to a total of **12 workweeks** of **unpaid** leave during the normal 12-month period established by the employer for FMLA leave for qualifying exigencies arising out of the fact that the employee's spouse, son, daughter, or parent is on active duty, or has been notified of an impending call or order to active duty, in support of a contingency operation.

Under the terms of the statute, qualifying exigency leave is available to a family member of a military member in the National Guard or Reserves; it does not extend to family members of military members in the regular Armed Forces.

Please refer to your FMLA policy for additional information regarding this benefit.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION

ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of February 17, 2010 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the WHIRLWIND STEEL BUILDINGS, INC. (referred to herein as the “Plan”) creates or receives about you. You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through 164 (the “Privacy Regulations”). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan’s privacy procedures with respect to your health information that is created or received by the Plan (your “Protected Health Information” or “PHI”). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan’s duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services (“HHS”) and the office to contact for further information about the Plan’s privacy practices.

How the Plan Will Use or Disclose Your PHI

Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to HHS;
- uses or disclosures that are required by law;

- uses or disclosures that are required for the Plan’s compliance with legal regulations; and

- uses and disclosures made pursuant to a valid authorization.

The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes.

The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

To Individuals Involved in Your Care. The Plan is permitted to disclose your PHI to your family members, other relatives and your close personal friends if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

Your Privacy Rights With Respect to PHI

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A “designated record set” includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your review rights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set. You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Right to Receive Confidential Communications

You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan's Duties With Respect to Your PHI

The Plan has the following duties with respect to your PHI:

- The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI.
- The Plan is required to abide by the terms of the notice that are currently in effect.
- The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.

Your Right to File a Complaint

You have the right to file a complaint with the Plan or HHS if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Complaint Official, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

Contact Information

If you would like to exercise any of your rights described in this Notice or to receive further information regarding HIPAA privacy, how the Plan uses or discloses your PHI, or your rights under HIPAA, you should contact the Privacy Official and Complaint Official for the Plan, Norma Hernandez, Whirlwind Steel Buildings, Inc., 8234 Hansen Road, Houston, TX 77074.

Certification

You have the right to obtain, from a prior employer or insurance carriers, a certification regarding any period of coverage which you or one of your dependents may have had which would be considered to be “creditable coverage”. If you need assistance in how to obtain such certification, you should contact the BCBSTX Customer Service Helpline.

In the event that you or one of your dependents subsequently become eligible for group health plan coverage under another employer’s plan or otherwise is eligible for other health insurance coverage, “creditable coverage” for prior coverage under the Health Program should be applicable to reduce any “pre-existing condition exclusion period” under such other group health plan coverage or health insurance coverage. You can obtain further information regarding your right to documentation of health coverage under the health program from BCBSTX Customer Service Helpline.

Privacy of Protected Health Information

The Health Insurance Portability and Accountability Act of 1996, as amended, (“HIPAA”) requires that the Plan must comply with HIPAA’s Privacy Standards.

In order for the Plan to provide benefits, it may be necessary for health care professionals, the Plan Administrator, personnel or individuals who perform Plan related functions under the guidance of the Plan Administrator, the Third Party Administrators, Insurance Companies and other service providers contracted to assist the Plan Administrator with the delivery of benefits, to have access to Protected health Information (“PHI”).

PHI is defined as individually identifiable health information about an employee or other covered person. Patient Records, which would include, but not limited to, all health records, physician, hospital and other medical professionals’ notes, health bills and claims filed for the employee or other covered person, oral or written information and all other individually identifiable health information related to an employee or other covered person are all considered PHI.

For any PHI received during the course of administering the Plan, the Plan Sponsor agrees:

- Not to use or disclose PHI other than as permitted or required by the Plan Document or as required by law (as defined in the Privacy Standards)
- To ensure that any agent, including a subcontractor, that receives PHI from the Plan Sponsor has agreed to the same restrictions and conditions that apply to the Plan Sponsor regarding PHI prior to the receipt of the PHI
- Not to use or disclose any PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan, except those authorized by the Privacy Standards.
- To report any PHI use or disclosure that is inconsistent with the uses or disclosure allowed by the Privacy Standards.
- To make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524)
- To make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526)
- To make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528)
- To make internal practices, books, and records relating to the use and disclosure of PHI received available to the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority has been delegated, for purpose of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (CR45 164.528).
- If possible, to return or destroy all PHI when no longer needed; and if not possible to limit further use or disclosure of PHI for other than the purpose originally designated.

- To ensure that proper separation between the Plan and the Plan Sponsor, as required in Section 164.504 (f)(2)(iii) of the Privacy Standards (45 CFR 164.504 (f)(2)(iii)), is established as follows:
 - the following employee or class of employees, or other persons under the control of the Plan Sponsor, shall be given access to the PHI to be disclosed: Benefits Manager and Director Compensation & Benefits and HR Administrator.
 - The access to and use of PHI by the employees described in the preceding sentence shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

In the event any of the employees indicated do not comply with the provisions of the Plan Document related to the use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (an oral warning, a written warning, suspension without pay and termination), if appropriate, and should be imposed based upon the severity of the violation.

Plan Administration activities are limited to activities that would meet the definition of payment or health care operations, but do not include the function to modify, amend or terminate the Plan or solicit bids from prospective issuers. Plan Administration functions include quality assurance, claims processing, auditing, monitoring and management of carve out plans, such as vision and dental. It does not include any employment related functions or functions in connection with any other benefit or benefits plans. The Plan shall disclose PHI to the Plan Sponsor only upon receipt of certification by the Plan Sponsor that the Plan has been amended to incorporate the above provisions and the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504 (f)(1)(iii) of the Privacy Standards (45 CFR 164.504 (f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an employee or covered person is participating in a Program or is enrolled in or has terminated from a health or other coverage offered by the Plan.

Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes the Plan, through the Plan Administrator, the Third Party Administrators, Insurance Companies and other service providers contracted to assist the Plan Administrator with the delivery of benefits, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to health claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

Women's Health and Protection Rights Act

The Women's Health and Cancer Rights Act of 1998 (Women's Health Act) includes protections for breast cancer patients who elect to have breast reconstruction in connection with a mastectomy. This plan includes benefits made available through the Women's Health and Cancer Rights Act of 1998. This law mandates that a participant or eligible beneficiary who is receiving benefits, on or after the law's effective date (January 1, 1999 for our Plan), for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to product a symmetrical appearance; and ■

Prostheses and treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance, and/or co-payment provisions otherwise applicable under the Plan.

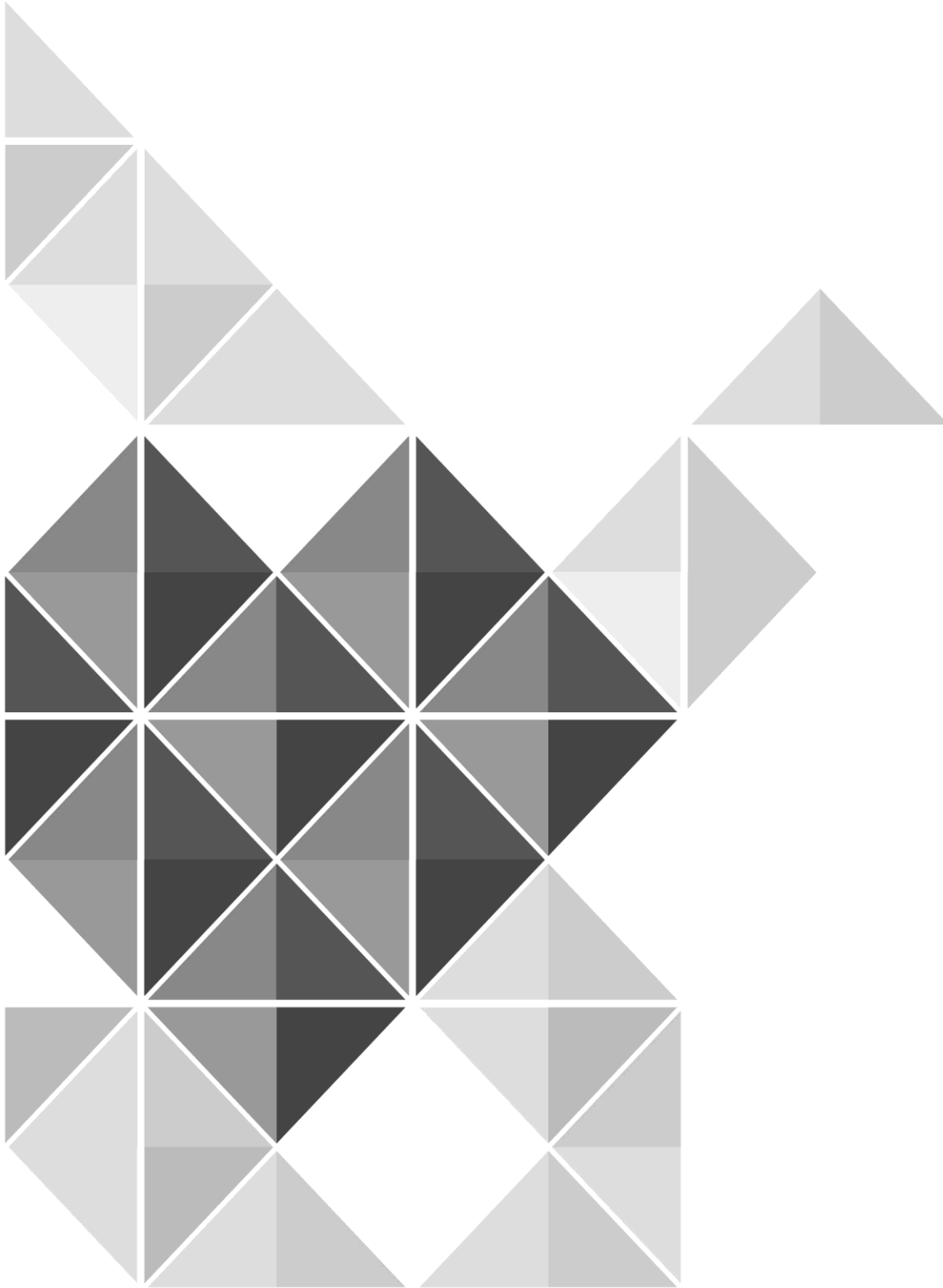
The Newborns' And Mothers' Health Protection Act

Under Federal law, benefits may not be restricted for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, benefits may be paid for a shorter stay if the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or newborn earlier. In addition, a plan may not require the provider to obtain authorization from the plan for prescribing a length of stay of up to 48 hours (or 96 hours).

Administered by:



**BlueCross BlueShield
of Texas**



bcbstx.com

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Blue Cross and Blue Shield of Texas provides administrative services only and does not assume any financial risk or obligation with respect to claims.