AcademicBlue℠

University of Texas System Student Health Insurance Plan 2026-2027

Underwritten by: Blue Cross and Blue Shield of Texas

Please review to understand your coverage.

Medical Account Number: 101464

AcademicBlue is offered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

9202234.0226

AcademicBlue℠

POLICYHOLDER:	University of Texas System
POLICY NUMBER:	101464 (“the Policy”)
EFFECTIVE DATE:	May 1, 2026
POLICY TERM:	May 1, 2026 through April 30, 2027
PREMIUM DUE DATE:	On or before Policy Effective Date

This Policy describes the terms and conditions of coverage as issued to the Policyholder named above. This Policy is issued in the state of Texas and is governed by its laws. This Policy becomes effective at 12:01 A.M. on the Policy Effective Date at the Policyholder’s address.

Blue Cross and Blue Shield of Texas (“BCBSTX”), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (“Insurer”, “We”, “Us”, and “Our”) and the Policyholder have agreed to all of the terms of this Policy as stated herein.

Policyholder has confirmed to us that it is an institution of higher education as defined in the Higher Education Act of 1965. This Policy does not make health insurance available other than in connection with enrollment as a Student (or a Dependent of a Student) in the Policyholder’s Institution. If you have any questions once you have read this Policy, you can call us at the toll-free telephone number on the back of your identification card. It is important to all of us that you understand the protection this coverage gives you.

Signed for Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company by:

James Springfield, Plan President
Blue Cross and Blue Shield of Texas

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE
PLEASE READ THIS POLICY CAREFULLY

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

NOTICE

Please note that Blue Cross and Blue Shield of Texas has contracts with many health care providers that provide for us to receive, and keep for our own account, payments, discounts and/or allowances with respect to the bill for services you receive from those providers.

Your out of pocket expenses will vary depending on many factors, such as the particular health care services, health care providers and particular benefit plan chosen.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of an out-of-network provider for treatment, services, and supplies not excluded or limited by this policy in non-emergency situations, benefit payments to such out-of-network providers are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by this policy.

YOU CAN EXPECT TO PAY MORE THAN THE **COINSURANCE** OR **COPAYMENT** AMOUNT DEFINED IN THE **POLICY** AFTER THE **PLAN** HAS PAID ITS REQUIRED PORTION WHEN **OUT-OF-NETWORK PROVIDERS** ARE USED.

Network providers have agreed to accept discounted payments for services with no additional billing to you other than applicable **copayments**, **coinsurance**, and **deductible** amounts. However, you may submit the appropriate documentation with a **claim** form to BCBSTX and allowable credit will, as applicable, be applied towards your network **deductible** and **out-of-pocket maximums** if:

- You pay the **provider** a rate less than the average discounted rate that would be paid by BCBSTX to a **network provider** directly for a covered and **medically necessary** service or supply
- The **provider** does not submit a **claim** to BCBSTX for that service or supply

Except in the circumstances described below, **out-of-network providers** may bill you for any amount up to the billed charge after the plan has paid its portion of the bill. However, you may submit the appropriate documentation with a **claim** form to BCBSTX and allowable credit will, as applicable, be applied towards your network **deductible** and **out-of-pocket maximums** if:

- You pay the **provider** a rate less than the average discounted rate that would be paid by BCBSTX to a **network provider** directly for a covered and **medically necessary** service or supply
- The **provider** does not submit a **claim** to BCBSTX for that service or supply

If services are obtained at a participating **hospital**, at a participating **surgery** center or other participating treatment center, and services are provided by an out-of-network anesthesiologist (including a certified registered nurse anesthetist), pathologist, radiologist, neonatologist, or emergency room **physician**, assistant surgeon (if the primary surgeon is a **network provider**) or other **hospital**-based **physician**, you will incur no greater out-of-pocket costs than would have been incurred if the services were provided by a **network provider**. For services provided by a Texas-licensed non-participating **provider**, unless you have signed a written notice and disclosure, in the form and following the requirements adopted by the Texas Department of Insurance, allowing the **out-of-network provider** to bill you for amounts above the non-contracting **allowed amount**, the non-participating **provider** may not bill you for the difference between payment by this **plan** and the **provider** charges plus in-network **deductible**, **coinsurance** and/or **copayment**. For services provided by

an **out-of-network provider** not licensed in Texas, the **out-of-network provider** may bill you for the difference between payment by the **plan** and the **provider** charges plus in-network **deductible**, **coinsurance** and/or **copayment**. Please call Customer Service if you have been balance billed by the **out-of-network provider**, or if you have any questions about the **benefits** described in this section (paragraph) or how your **claims** have been processed.

You may obtain further information about the participating status of **providers** and information on **out-of-pocket maximums** by calling the toll-free telephone number on the back of your identification card.

For questions concerning **out-of-network providers**, please call Blue Cross and Blue Shield of Texas Customer Service at the toll-free telephone number on the back of your identification card. Should you wish to know the **allowable amount** for a particular health care service or procedure or whether a particular **provider** is a **network provider** or an **out-of-network provider**, contact your **provider** or Blue Cross and Blue Shield of Texas. Should you wish to know the estimated **claim charge** for a particular health care service or procedure, please contact your **provider**.

Have a complaint or need help?

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

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

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
To get information or file a complaint with your insurance company or HMO:
Call: Blue Cross and Blue Shield of Texas
Toll-Free: 1-888-654-9390
Email: BCBSTXComplaints@bcbstx.com
Mail: P. O. Box 660044, Dallas, TX 75266-0044

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

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

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

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Blue Cross and Blue Shield of Texas
Teléfono gratuito: 1-888-654-9390
Correo electrónico: BCBSTXComplaints@bcbstx.com
Dirección postal: P. O. Box 660044, Dallas, TX 75266-0044

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439 Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-OP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

YOUR RIGHTS WITH A PREFERRED PROVIDER BENEFIT PLAN (PPO)

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

Health care costs

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

List of doctors

You can get a directory of health care providers that are in your plan's network. You can get the directory online at www.bcbstx.com or by calling 1-800-521-2227. If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Health care bills

If you want to see a doctor or facility that isn't in your plan's network, you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay.

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

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ELIGIBILITY FOR INSURANCE

Each person in one of the classes of eligible persons shown below is eligible to be insured under this **policy**. This includes anyone who is eligible on this **policy** effective date and may become eligible after this **policy** effective date while this **policy** is in force. You must meet the **institution's** requirements for maintaining your status as an eligible **student**. Please contact your **institution** for further information. You must maintain their eligibility in order to maintain or continue coverage under this **policy**. **Students** enrolled for the summer sessions will not experience a loss in coverage as long as they were covered immediately preceding summer sessions. (These **students** may be eligible for continuation coverage as provided for in this **policy**.) We maintain the right to investigate **student** status and attendance records to verify that eligibility requirements have been met.

Classes Of Eligible Persons

Class 1: **Health Institution Students** (Hard Waiver) All Health Institutions and medical students are automatically enrolled in the student health insurance plan at registration unless proof of comparable coverage is furnished.

Class 2: **International Students** (Mandatory) All international students holding non-immigrant visas are required to purchase this student health insurance plan in order to complete registration, except for those students who provide proof of comparable coverage in writing.

ALL OTHER STUDENTS (VOLUNTARY)

Class 3: **Voluntary Undergraduate Students** - All fee-paying undergraduate students at UT System taking at least seven (7) credit hours each semester, are eligible to enroll in SHIP.

Class 4: **Voluntary Graduate Students** - All fee-paying graduate students enrolled in at least four (4) credit hours each semester, are eligible to enroll in SHIP.

Class 5: **Other Voluntary Students** - Students working on research, dissertation, or thesis, post doctorate, scholars, fellows, visiting scholars, ESL program students, Fast Track Degree Program students, students who are deemed full-time by the campus Disability Services department, or other groups with reduced coursework that meet the criteria for exemption as defined and approved by UT System are eligible to enroll in SHIP.

Class 6: **Summer Undergraduate Students** taking four (4) credit hours are eligible to enroll in SHIP.

Class 7: **Summer Graduate Students** taking two (2) credit hours are eligible to enroll in SHIP.

Class 8: **Academic Graduate Student Employees and SUPER Scholars** are eligible to enroll in SHIP.

NOTE: Multiple classes may be added depending on the **institution**.

A person may be insured only under one class of eligible persons even though they may be eligible under more than one class.

Dependents, as defined by this **policy**, of all **students** are eligible for coverage under this **policy**.

A person may not be insured as a **dependent** and a **student** at the same time.

A **student's dependent** is eligible on the date:

- You are eligible if you have **dependents** on that date
- The date the person becomes a **dependent** of you, if later

Individuals who are eligible to receive Medicare benefits are not eligible to enroll in this plan unless they fall within a Federal exception.

No eligibility rules or variations in premium will be imposed based on a student's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, quality of life, or any other health status factor. A student will not be discriminated against for coverage under this policy on the basis of race, color, national origin, disability, age, expected length of life, sex, gender identity, sexual orientation, religion, or political affiliation. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving benefits. Variations in the administration, processes or benefits of this policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

SCHEDULE OF BENEFITS

Your **benefits** are highlighted below. However, to fully understand your **benefits**, it is very important that you read this entire **policy**. Although you can go to the **hospital** or **provider** of your choice, **benefits** under this **policy** will be greater when you use the services of a **network provider**.

Deductible	Network Provider	Out-of-Network Provider
Per Covered Person per Benefit Period:	$350	$700
Per Family per Benefit Period:	$1,050	$2,100

Out-of-Pocket Maximum	Network Provider	Out-of-Network Provider
Per Covered Person per Benefit Period:	$8,700	$17,400
Per Family per Benefit Period:	$17,400	$34,800

Student Health Center
Professional services received at the Student Health Center will be covered at 100% of Allowable Amount. Deductible waived.

Covered Expenses	Network Provider Covered Person Pays	Out-of-Network Provider* Covered Person Pays
Inpatient Expenses		
Hospital Expenses	20% of Allowable Amount	40% of Allowable Amount
Surgical Expenses for a primary procedure - Remaining eligible procedures. When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full Allowable Amount for that procedure.	20% of Allowable Amount	40% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	40% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	40% of Allowable Amount
Doctor's Visits	20% of Allowable Amount	40% of Allowable Amount
Mental Health Care/Chemical Dependency	20% of Allowable Amount	40% of Allowable Amount
Emergency Room Accidents and Emergency Care (including Accidents, and Emergency and Non-Emergency Care for Behavioral Health Services)		
Facility Charges (excluding Certain Diagnostic Procedures) (Copayment is waived if admitted to the Hospital as an Inpatient immediately following emergency treatment; Inpatient hospital expenses will apply).	20% of Allowable Amount Subject to a $150 Copayment (Waived if admitted to the Hospital as an Inpatient immediately following emergency treatment) Deductible Waived	
- Physician Charges	20% of Allowable Amount	
- Lab and X-ray Charges	20% of Allowable Amount	

Emergency Room Non-Emergency Care		
Facility charges (excluding Certain Diagnostic Procedures)	20% of Allowable Amount Subject to a $150 Copayment (Waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	40% of Allowable Amount Subject to a $150 Copayment (Waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)
- Physician Charges	20% of Allowable Amount	40% of Allowable Amount
- Lab and X-ray Charges	20% of Allowable Amount	40% of Allowable Amount
Outpatient Expenses		
Surgical Expenses for a primary procedure - Remaining eligible procedures. When multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full Allowable Amount for that procedure.	20% of Allowable Amount	40% of Allowable Amount
Day Surgery Miscellaneous Expenses	20% of Allowable Amount	40% of Allowable Amount
- Assistant Surgeon Services	20% of Allowable Amount	40% of Allowable Amount
- Anesthetist Services	20% of Allowable Amount	40% of Allowable Amount
Office Visits Including Office Visits for Behavioral Health Services	Subject to a $30 Copayment Deductible Waived	40% of Allowable Amount
Specialist Office Visits Including Specialist Office Visits for Behavioral Health Services	Subject to a $35 Copayment Deductible Waived	40% of Allowable Amount
Telehealth, Telemedicine, and Teledentistry Physician Visits Including Telehealth and Telemedicine Physician Visits for Behavioral Health Services	Subject to a $30 Copayment Deductible Waived	40% of Allowable Amount
Telehealth, Telemedicine, and Teledentistry Specialist Physician Visits Including Telehealth and Telemedicine Physician Visits for Behavioral Health Services	Subject to a $35 Copayment Deductible Waived	40% of Allowable Amount
Urgent Care	Subject to a $35 Copayment Deductible Waived	40% of Allowable Amount
Habilitation Services Benefits will be limited to 35 visits per Benefit Period. (Therapies associated with developmental delays will not be limited to annual or lifetime maximums) (Visit limitations do not apply to Behavioral Health Services)	20% of Allowable Amount	40% of Allowable Amount
Rehabilitation Services Benefits will be limited to 35 visits per Benefit Period. (Therapies associated with developmental delays will not be limited to annual or lifetime maximums) (Visit limitations do not apply to Behavioral Health Services)	20% of Allowable Amount	40% of Allowable Amount

Diagnostic X-ray and Laboratory Services	20% of Allowable Amount	40% of Allowable Amount
Radiation and Chemotherapy	20% of Allowable Amount	40% of Allowable Amount
Allergy Injections and Allergy Testing (Copay may apply if billed in the office)	20% of Allowable Amount	40% of Allowable Amount
Home Infusion Therapy	20% of Allowable Amount	40% of Allowable Amount
Cardiac Rehabilitation Services	20% of Allowable Amount	40% of Allowable Amount
Durable Medical Equipment	20% of Allowable Amount	40% of Allowable Amount
Prosthetic and Orthotic Devices - Limited to most appropriate model that meets medical needs	20% of Allowable Amount	40% of Allowable Amount
Ground and Air Ambulance Services	20% of Allowable Amount	
Organ and Tissue Transplants The transplant must meet the criteria established by BCBSTX for assessing and performing organ or tissue transplants as set forth in BCBSTX's written medical policies.	20% of Allowable Amount	40% of Allowable Amount
Maternity	20% of Allowable Amount	40% of Allowable Amount
Complications of Pregnancy	20% of Allowable Amount	40% of Allowable Amount
Routine Well-Baby Care	No Charge	40% of Allowable Amount
Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	
Tests and Procedures	20% of Allowable Amount	40% of Allowable Amount
Speech and Hearing Services Benefits for Hearing Aids will be limited to one Hearing Aid per ear each 36-month period.	20% of Allowable Amount	40% of Allowable Amount
Mental Health Care/Chemical Dependency	20% of Allowable Amount	40% of Allowable Amount
Needle Stick, only for Students doing course work or Hospital training	No Charge	40% of Allowable Amount
Skilled Nursing Facility Benefits will be limited to 25 days per Benefit Period	20% of Allowable Amount	40% of Allowable Amount
Coordinated Home Health Care Benefits will be limited to 60 visits per Benefit Period	20% of Allowable Amount	40% of Allowable Amount
Hospice Benefits are Unlimited	20% of Allowable Amount	40% of Allowable Amount
Preventive Care Services	No Charge	40% of Allowable Amount
Well Child Immunizations - up to age 6	No Charge	No Charge
Screening Test for Hearing Loss - within 30 days from date of birth	No Charge	40% of Allowable Amount
Amino Acid-Based Formulas – if Doctor orders and Medically Necessary	20% of Allowable Amount	40% of Allowable Amount

Autism Spectrum Disorders for covered Dependents Visit limits specified under "Outpatient Therapy Services" for Physical Therapy, Occupational Therapy and Speech Therapy are not applicable to treatment of Autism and Autism Spectrum Disorders	20% of Allowable Amount	40% of Allowable Amount
Inheritable Metabolic Disorders	20% of Allowable Amount	40% of Allowable Amount
Craniofacial Abnormalities	20% of Allowable Amount	40% of Allowable Amount
Mammography, Diagnostic Imaging, and Pap Smear Testing	No Charge	40% of Allowable Amount
Mastectomy and Lymph Node Dissection – minimum Inpatient stay	20% of Allowable Amount	40% of Allowable Amount
Bone Density Testing	No Charge	40% of Allowable Amount
Colorectal Cancer Screening	No Charge	40% of Allowable Amount
Prostate Cancer Screening	Subject to a $30 Copayment Deductible Waived	40% of Allowable Amount
Screening for early detection of cardiovascular disease limited to a maximum of 1 test every 5 years for: - Men ages 46 to 75 years - Women ages 56 to 75 years	20% of Allowable Amount	40% of Allowable Amount
Diabetes - includes all Medically Necessary equipment, supplies, medications, labs and Outpatient self-management training and educational services	20% of Allowable Amount	40% of Allowable Amount
Acquired Brain Injury - includes multiple therapies and Rehabilitation treatments	20% of Allowable Amount	40% of Allowable Amount
Temporomandibular and Craniomandibular Joint Disorders - includes diagnosis and surgical treatment	20% of Allowable Amount	40% of Allowable Amount
Clinical Trial Programs - routine patient costs for Phase I, II, III or IV trials	20% of Allowable Amount	40% of Allowable Amount
Cochlear Implants – limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	20% of Allowable Amount	40% of Allowable Amount
Orally Administered Anticancer Medication - when Medically Necessary	20% of Allowable Amount	40% of Allowable Amount

The **copayment** and **coinsurance** amounts mentioned above are subject to change or increase as permitted by applicable law.

*You will be responsible for the difference between the **allowable amount** and the billed charges when receiving **covered services** from an **out-of-network provider**. For questions concerning **out-of-network providers**, please call Blue Cross and Blue Shield of Texas Customer Service at the toll-free telephone number on the back of your identification card.

SCHEDULE OF BENEFITS FOR OUTPATIENT PRESCRIPTION DRUGS

Student Health Center Pharmacy Benefit

Student Health Center Pharmacy Benefit*	Student Health Center Pharmacy Covered Person Pays
Preferred Generic Drugs and Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment
Non-Preferred Generic Drugs and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment
Preferred Brand Name Drugs and Preferred Brand name diabetic supplies, insulin, and insulin syringes	$30 Copayment
Non-Preferred Brand Name Drugs and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	$50 Copayment
Preferred Specialty Drugs	20% of Allowable Amount
Non-Preferred Specialty Drugs	20% of Allowable Amount

*One prescription means up to a 30 consecutive day supply of a drug (except for certain drugs).

Students can purchase a 90-day supply for 3 times the schedule amount listed above.

Retail Pharmacy Benefit

Retail Pharmacy Benefit*	Network Provider Pharmacy Covered Person Pays	Out-of-Network Pharmacy Covered Person Pays**
Preferred Generic Drugs and Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment	40% of Allowable Amount After a $15 Copayment
Non-Preferred Generic Drugs and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment	40% of Allowable Amount After a $15 Copayment
Preferred Brand Name Drugs and Preferred Brand Name diabetic supplies, insulin, and insulin syringes	$30 Copayment	40% of Allowable Amount After a $30 Copayment
Non-Preferred Brand Name Drugs and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	$50 Copayment	40% of Allowable Amount After a $50 Copayment
Preferred Specialty Drugs	20% of Allowable Amount	40% of Allowable Amount
Non-Preferred Specialty Drugs	20% of Allowable Amount	40% of Allowable Amount
Certain Covered Drugs may be available at no cost through a Participating Pharmacy for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses and nitrates. For further information, call the toll-free telephone number on the back of your identification card.		
Select Covered drugs, determined by the Plan, may be covered with no member cost share, to make these medications more affordable to you.		
Extended Retail Prescription Drug Supply Program One Copayment per 30-day supply, up to a 90-day supply***		

* One prescription means up to a 30 consecutive day supply of a drug (except for certain drugs). You can purchase up to a 90-day supply for 3 times the retail amount. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

** Out-of-network **pharmacies**: When you obtain **prescription drugs**, including diabetic supplies from an out-of-network **pharmacy**, **benefits** will be provided at 60% of the amount you would have received had you obtained drugs from a **network pharmacy** minus the **copayment** or **coinsurance** amount.

You will be responsible for the difference between the **allowable amount** and the billed charges, when receiving **prescription drugs** from an out-of-network **pharmacy**.

Mail Order Prescription Drug Program

Mail Order Pharmacy Benefit*	Mail Order Pharmacy Covered Person Pays
Preferred Generic Drugs and Preferred Generic diabetic supplies, insulin, and insulin syringes	$40 Copayment per Prescription
Non-Preferred Generic Drugs and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	$40 Copayment per Prescription
Preferred Brand Name Drugs and Preferred Brand Name diabetic supplies, insulin, and insulin syringes	$75 Copayment per Prescription
Non-Preferred Brand Name Drugs and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	$125 Copayment per Prescription
Preferred Specialty Drugs	20% of Allowable Amount per Prescription
Non-preferred Specialty Drugs	20% of Allowable Amount per Prescription

*One prescription means up to a 90 consecutive day supply of a drug (except for certain drugs). Certain drugs may be limited to less than a 90 consecutive day supply.

Specialty Pharmacy Benefit

Specialty Pharmacy Benefit*	Specialty Pharmacy Covered Person Pays
Preferred Generic Drugs and Preferred Generic diabetic supplies, insulin, and insulin syringes	N/A
Non-Preferred Generic Drugs and Non-Preferred Generic diabetic supplies, insulin, and insulin syringes	N/A
Preferred Brand Name Drugs and Preferred Brand Name diabetic supplies, insulin, and insulin syringes	N/A
Non-Preferred Brand Name Drugs and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	N/A
Preferred Specialty Drugs	20% of Allowable Amount
Non-preferred Specialty Drugs	20% of Allowable Amount

*Coverage for **specialty drugs** are limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your plan **benefits**. Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

IMPORTANT INFORMATION

This is your **student** health insurance **policy**. It describes your **covered services**, what they are, and how you obtain them.

The defined terms are in bold and are defined in the GLOSSARY.

The terms "you" and "your" are used in reference to the **student**.

The terms "we", "us", and "our" is to describe the Blue Cross and Blue Shield plan that is the claim administrator.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Accident And Sickness Medical Expense Benefits

Unless otherwise specified, any **deductibles**, **copayments**, **coinsurance** percentages, **out-of-pocket maximums** and **benefit maximums** apply on a per person, per **benefit period** basis.

Deductible

After the **deductible** and any **copayments** have been satisfied, **benefits** will be paid at the applicable **benefit** rate up to any maximum that may apply.

If you have **family coverage**, each member of your family must satisfy the **deductible**. If your family has satisfied the family **deductible** amount of $1,050 for **covered expenses** rendered by **network provider(s)** and a separate $2,100 family **deductible** for **covered expenses** rendered by **out-of-network provider(s)**, it will not be necessary for anyone else in your family to meet the **deductible** in that **benefit period**. That is, for the remainder of that **benefit period** only, no other family members(s) will be required to meet the **deductible** before receiving **benefits.**

Out-Of-Pocket Maximum

Once the **out-of-pocket maximum** has been satisfied, with the exception of any applicable out-of-network **copayment**, **covered expenses** will be payable at 100% for the remainder of the **benefit period** up to any maximum that may apply.

The network **out-of-pocket maximum** may be reached by:

- The network **deductible**
- Charges for the **outpatient prescription drugs**
- The **hospital** emergency room **copayment**
- The **copayment** for office visits
- The **copayment** for specialist's office visits
- The urgent care facility **copayment**
- The payments for which you are responsible after **benefits** have been provided (except for the cost difference between the **hospital's** rate for a private room and a semi-private room or any expenses incurred for **covered services** rendered by an **out-of-network provider** other than **emergency care**, and **inpatient** treatment during the period of time when your condition is serious)

The following expenses cannot be applied to the network **out-of-pocket maximum** and will not be paid at 100% of the **allowable amount** when your network **out-of-pocket maximum** is reached:

- Charges that exceed the **allowable amount**
- The **coinsurance** resulting from **covered services** rendered by an **out-of-network provider**
- Penalty amounts for failing to follow **prior authorization** requirements
- Services, supplies, or charges limited or excluded in this **policy**
- Expenses not covered because a **benefit** maximum has been reached
- Any **covered expenses** paid by the primary plan when BCBSTX is the secondary **plan** for purposes of coordination of **benefits**

The out-of-network **out-of-pocket maximum** may be reached by:

- The out-of-network **deductible**
- Charges for **outpatient prescription drugs**
- The **hospital** emergency room **copayment**
- The urgent care facility **copayment**
- The payments for **covered services** rendered by an **out-of-network provider** for which you are responsible after **benefits** have been provided (except for the cost difference between the **hospital's** rate for a private room and a semi-private room)

The following expenses cannot be applied to the out-of-network **out-of-pocket maximum** and will not be paid at 100% of the **allowable amount** when your out-of-network **out-of-pocket maximum** is reached:

- Charges that exceed the **allowable amount**
- The **coinsurance** resulting from **covered services** you may receive from a **network provider**
- Penalty amounts for failing to follow **prior authorization** requirements
- Services, supplies, or charges limited or excluded in this **policy**
- Expenses not covered because a **benefit** maximum has been reached
- Any **covered expenses** paid by the primary plan when BCBSTX is the secondary **plan** for purposes of coordination of **benefits**

If you have **family coverage**, each member of your family must satisfy the **out-of-pocket maximum**. If your family has satisfied the family **out-of-pocket maximum** of $17,400 for **covered expenses** rendered by **network provider(s)** and a separate $34,800 family **out-of-pocket maximum** for **covered expenses** rendered by **out-of-network provider(s)**, it will not be necessary for anyone else in your family to meet the **out-of-pocket maximum** in that **benefit period**. That is, for the remainder of that **benefit period** only, no other family member(s) will be required to meet the **out-of-pocket maximum** before **covered expenses** (except for those expenses specifically excluded above) will be payable at 100%.

Should the federal government adjust the Deductible(s) and/or Out-of-Pocket Maximum(s) applicable to this type of coverage, the Deductible and/or the Out-of-Pocket Maximum(s) in this Policy will be adjusted accordingly.

UTILIZATION MANAGEMENT

Utilization Management

Utilization Management may be referred to as **medical necessity** reviews, utilization reviews (UR) or medical management reviews. **Medical necessity** reviews for a procedure/service, inpatient admission, and length of stay is based on BCBSTX medical policy and/or level of care review criteria. **Medical necessity** reviews may occur prior to services rendered, during the course of care, or after care has been completed for a post-service **medical necessity** review. However, some services may require **prior authorization** before the start of services, while other services will be subject to a post-service **medical necessity** review. If requested, services normally subject to a post-service **medical necessity** review may be reviewed for **medical necessity** prior to the service through a recommended clinical review as defined below.

Refer to the definition of **medical necessity** or **medically necessary** in the GLOSSARY section of this **policy** for additional information regarding any limitations and/or special conditions pertaining to your **benefits**.

Prior Authorization

Prior authorization establishes in advance the **medical necessity** or **experimental/investigational** nature of certain care and services covered under this **policy**. It ensures that the care and services described below for which you have obtained **prior authorization** will not be denied on the basis of **medical necessity** or being **experimental/investigational** in nature.

Some Texas licensed **providers** may qualify for an exemption from required **prior authorization** requirements for a particular health care service if the **provider** meets criteria set forth by applicable law for the particular health care service. If so, **prior authorization** is not required for a particular service where an exemption applies and will not be denied based on **medical necessity**. Other **providers** providing your care may not be exempt from such requirements.

If prior authorization is required, the review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this policy. BCBSTX recommends you confirm with your provider if prior authorization has been obtained.

Prior Authorization Responsibility

Network Provider Prior Authorization

Your **network provider** is responsible for obtaining **prior authorization**, in those circumstances where **prior authorization** may be required. If **prior authorization** is not obtained and the services are denied as not **medically necessary**, the participating **provider** will be held responsible and will not be able to bill you for the services.

For additional information about **prior authorization** for services outside of our service area, refer to the Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements Notice in the NOTICES section of this **policy**.

Note: **Providers** that contract with other Blue Cross and Blue Shield **plans** are not familiar with the **prior authorization** requirements of BCBSTX. Unless a **provider** contracts directly with BCBSTX as a **network provider**, the **provider** is not responsible for being aware of this **policy's prior authorization** requirements.

Out-of-Network Prior Authorization

If any **provider** outside Texas (except for those contracting as **network providers** directly with BCBSTX) or any **out-of-network provider** recommends an **inpatient** admission or a service that requires **prior authorization**, the **provider** is not obligated to obtain the **prior authorization** for you. In such cases, it is your responsibility to ensure that **prior authorization** is obtained. If **prior authorization** is not obtained before services are received, you may be entirely responsible for the charges if the service is determined not to be **medically necessary**. If the service is determined to be **medically necessary**, out-of-network **benefits** will apply. The **provider** may call on your behalf, but it is your responsibility to ensure that BCBSTX is called.

To determine if a specific service or category requires **prior authorization**, visit the website at www.bcbstx.com/find-care/utilization-management for the required **prior authorization** list, which is updated when new services are added or when services are removed. You can also call BCBSTX Customer Service at the toll-free telephone number on the back of your identification card.

Inpatient Admissions

In order to receive maximum **benefits**, you, your authorized representative, or your **provider** may need to obtain **prior authorization** from the **plan** for an **inpatient** admission, if **inpatient** admissions are identified as needing **prior authorization**. In the case of an elective **inpatient** admission, if services require **prior authorization**, it is recommended that the call for **prior authorization** should be made at least two working days before you are admitted unless it would delay **emergency care**. In an emergency, it is requested that notification should take place within two working days after admission, or as soon thereafter as reasonably possible.

Your **network provider** is required to obtain **prior authorization** for any **inpatient** admissions that may require **prior authorization**. If **prior authorization** is not obtained for **inpatient** services and the services are denied as not **medically necessary**, the participating **provider** will be held responsible and will not be able to bill you for the services.

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 **prior authorization** by the **plan** by calling the toll-free telephone number 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 not later than 24 hours after the call is received. We will follow up with your **provider's** office. After working hours or on weekends, please call the Medical Prior Authorization Helpline toll-free telephone number on the back of your identification card. Your call will be recorded and returned the next working day. A **benefits** management nurse will follow up with your **provider's** office. All timelines for **prior authorization** requirements are provided in keeping with applicable state and federal regulations**.**

In-network **benefits** will be available if you use a **network provider**. 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 reasonably available from **network providers** as defined by applicable law, and BCBSTX authorizes your visit to an **out-of-network provider** to be covered at the in-network **benefit** level *prior to the visit,* in-network **benefits** will be paid; otherwise, out-of-network **benefits** will be paid.

When **prior authorization** of an **inpatient** admission is obtained, a length-of-stay is assigned. Your **provider** may seek an extension for the additional days if you require a longer stay. **Benefits** will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the LENGTH OF STAY/SERVICE REVIEW section of this **policy**.

For **behavioral health inpatient** admissions, please see the CONTACTING BEHAVIORAL HEALTH section below.

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

Your **plan** is required to provide a minimum length of stay in a **hospital** facility for the following:

- Maternity Care
    1. 48 hours following an uncomplicated vaginal delivery
    2. 96 hours following an uncomplicated delivery by caesarean section

- Treatment of Breast Cancer
    1. 48 hours following a mastectomy
    2. 24 hours following a lymph node dissection

You or your **provider** will not be required to obtain **prior authorization** from BCBSTX for a length of stay less than 48 hours (or 96 hours) for maternity care or less than 48 hours (or 24 hours) for treatment of breast cancer. If you require a longer stay you, your authorized representative, or your **provider** must seek an extension for the additional days by obtaining **prior authorization** from BCBSTX.

Outpatient Service Review

If prior authorization is required, the review is not a guarantee of **benefits**. Actual availability of **benefits** is subject to eligibility and the other terms, conditions, limitations, and exclusions of this policy. BCBSTX recommends you confirm with your **provider** if **prior authorization** has been obtained.

There may be general categories of **covered services** that require **prior authorization**.

To determine if a specific service or category requires **prior authorization**, visit the website at www.bcbstx.com/find-care/utilization-management for the required **prior authorization** list, which is updated when new services are added or when services are removed. You can also call BCBSTX Customer Service at the toll-free telephone number on the back of your identification card.

For **behavioral health outpatient** service review please see CONTACTING BEHAVIORAL HEALTH section below.

Prior Authorization Renewal Process

Renewal of an existing **prior authorization** issued by BCBSTX can be requested by a **physician** or health care **provider** up to 60 days prior to the expiration of the existing **prior authorization**.

Extension of Length of Stay/Service Review (Concurrent Review)

Length of Stay/Service Review is not a guarantee of **benefits**. Actual availability of **benefits** is subject to eligibility and the other terms, conditions, limitations, and exclusions of this **policy**.

An extension of a previously approved Length of Stay/Service Review will be based solely on whether continued **inpatient** care or other health care services are **medically necessary**. If the extension is determined not to be **medically necessary**, the coverage for the length of stay/service will not be extended, except as otherwise described in the CLAIM FILING AND APPEALS PROCEDURES section of this **policy**.

An extension of Length of Stay/Service Review, also known as a concurrent **medical necessity** review, is when you, your **provider**, or other authorized representative may submit a request to BCBSTX for continued services. If you, your **provider**, or authorized representative requests to extend care beyond the approved time limit, BCBSTX will make a determination on the request within the timeframes described in the REVIEW OF CLAIM DETERMINATIONS provision of this **policy**.

Recommended Clinical Review Option

There are services that do not require a **prior authorization** that may be subject to a post-service **medical necessity** review before the **claim** is paid. There is an option for your **provider** to request a recommended clinical review to determine if the service meets approved BCBSTX medical policy and/or level of care review criteria before services are provided to you. Once a decision has been made on the services reviewed as part of the recommended clinical review process, the same services will not be reviewed for **medical necessity** after they have been performed.

To determine if a recommended clinical review is available for a specific service, visit the website at www.bcbstx.com/find-care/utilization-management for the recommended clinical review list, which is updated when new services are added or when services are removed. You can also call BCBSTX Customer Service at the toll-free telephone number on the back of your identification card. This website also includes information on which services require **prior authorization** before services are performed.

Recommended clinical review is a determination of the **medical necessity** of a proposed service, but it is not a guarantee of **benefits**. Actual availability of **benefits** is subject to eligibility and the other terms, conditions, limitations and exclusions of this **policy**. Please coordinate with your **provider** to submit a written request for recommended clinical review.

In the event a recommended clinical review determines the proposed services are not **medically necessary**, you have the right to file an appeal as described in the CLAIM FILING AND APPEALS PROCEDURES section of this **policy**. All appeal and review requirements related to **medical necessity** determinations, including independent review, apply to services where your **provider** requests a recommended clinical review.

Contacting Behavioral Health

You, your **physician**, **provider** of services, or your authorized representative may contact BCBSTX for **prior authorization** or recommended clinical review by calling the toll-free telephone number on the back of your identification card and following the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate **behavioral health** clinical team for review. **Outpatient** requests should be

requested during regular business hours. After 6:00 PM, on weekends, and on holidays, the same **behavioral health** line is answered by clinicians available for **inpatient acute** reviews only. Requests for residential or partial hospitalization are reviewed during regular business hours.

General Provisions Applicable to All Recommended Clinical Reviews

1. No Guarantee of Payment

A recommended clinical review is not a guarantee of **benefits** or payment of **benefits** by BCBSTX. Actual availability of **benefits** is subject to eligibility and the other terms, conditions, limitations, and exclusions of this **plan**. Even if the service has been approved on recommended clinical review, coverage or payment can be affected for a variety of reasons. For example, you may have become ineligible as of the date of service or your **benefits** may have changed as of the date of service.

2. Request for Additional Information

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

Post-Service Medical Necessity Review

A post-service **medical necessity** review, sometimes referred to as a retrospective review or post-service **claims** request, is the process of determining coverage after treatment has been provided and is based on **medical necessity** guidelines. A post-service **medical necessity** review confirms your eligibility, availability of **benefits** at the time of service, and reviews necessary clinical documentation to ensure the service was **medically necessary**. **Providers** should submit appropriate documentation at the time of a post-service review request. A post-service **medical necessity** review may be performed when **prior authorization** or a recommended clinical review was not obtained prior to services being rendered.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

A post-service **medical necessity** review is not a guarantee of **benefits**. Actual availability of **benefits** is subject to eligibility and the other terms, conditions, limitations, and exclusions of this **plan**. Post-service **medical necessity** review does not guarantee payment of **benefits** by BCBSTX, for instance you may become ineligible as of the date of service or your **benefits** may have changed as of the date of service.

2. Request for Additional Information

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

Failure to Obtain Prior Authorization

If **prior authorization** is not obtained:

1. BCBSTX will review the **medical necessity** of your treatment or service prior to the final **benefit** determination.
2. If BCBSTX determines the treatment or service is not **medically necessary** or is **experimental/investigational**, **benefits** will be reduced or denied.
3. You may be responsible for a penalty for certain **covered services**, if indicated on your SCHEDULE OF BENEFITS.

Network providers are responsible for satisfying the **prior authorization** requirements for any **inpatient** admissions. If **prior authorization** is not obtained, the **network provider** will be sanctioned based on the BCBSTX contractual agreement with the **provider**, and no penalty charges will be deducted.

GLOSSARY

Throughout this policy, many words are used which have a specific meaning when applied to your health care coverage. These terms will always be bolded. When you come across these terms while reading this policy, you can refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your benefits. If a term within a definition is bolded, it means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER. In this policy we refer to our company as "Blue Cross and Blue Shield of Texas" and we refer to the institution of higher education in which you are enrolled and active as the "institution."

Accident means a sudden, unexpected, and unintended identifiable event producing at the time objective symptoms of an **injury**. The **accident** must occur while you are insured under this **policy**.

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

For **hospitals, doctors** and **other providers** contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan - The **allowable amount** is based on the terms of the **network 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, doctors** and **other providers** not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting **allowable amount**) - The **allowable amount** will be the lesser of: (1) the **provider's** billed charges, or; (2) the BCBSTX non-contracting **allowable amount**. Except as otherwise provided in this section, the non-contracting **allowable amount** is developed from base Medicare participating reimbursements adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting **allowable amount** for home health care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by home health discipline type adjusted for duration and adjusted by a predetermined factor established by Us. 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 us. Such factor shall be not less than 75% and shall be updated not less than every two years.

We 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 we do not have any **claim** edits or rules, We 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 us 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 you 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, you may call Customer Service at the toll-free telephone number on the back of your 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 **prescription drugs** as applied to **network pharmacies** and **out-of-network pharmacies -** The **allowable amount** for **pharmacies** that are **network provider**s will be based on the provisions of the contract between BCBSTX and the **pharmacy** in effect on the date of service. The **allowable amount** for **pharmacies** that are not **network pharmacies** will be based on the **average wholesale price**.

For non-**emergency care** provided by an **out-of-network provider** when a contracting **provider** is not reasonably available as defined by applicable law or when services are pre-approved or when **prior authorization** is obtained based upon the unavailability of a preferred **provider** and balance billing is not prohibited by Texas law - The **allowable amount** will be the **plan** usual and customary charge as defined by Texas law or as prescribed under applicable law and regulations, or at a rate agreed to between BCBSTX and the **out-of-network provider**, not to exceed billed charges for out-of-network **emergency care,** care provided by an out-of-network facility-based **provider** in a network **hospital,** ambulatory **surgery** center or birthing center, or services provided by an out-of-network laboratory or diagnostic imaging service in connection with care delivered by a **network provider**

The **allowable amount** will be the **plan's** usual and customary rate or at a rate agreed to between BCBSTX and the **out-of-network provider** as prescribed by the Texas Insurance Code, not to exceed billed charges. The **plan's** usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less than the non-contracting **allowable amount** as defined in this **policy**.

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

Behavioral Health means mental health, **serious mental illness**, or **chemical dependency**.

Behavioral Health Practitioner means a **physician** or **professional other provider** who renders services for **mental health care**, **serious mental illness** or **chemical dependency**.

Benefit means the payment, reimbursement, and indemnification of any kind which you will receive from, and through the **plan**, under this **policy**.

Benefit Period means the period of time starting with the effective date of this **policy** through the termination date as shown on the face page of this **policy**. The **benefit period** is as agreed to by the **policyholder** and BCBSTX.

Biomarker means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to the specific therapeutic intervention, including gene mutations and protein expression.

Biomarker Testing means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a **biomarker**, including, but not limited to, single-analyte tests, multi-plex panel tests, and partial or whole genome sequencing.

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

Certain Diagnostic Procedures means:

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

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

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of **chemical dependency** pursuant to a written treatment plan approved and monitored by a **behavioral health practitioner** and which facility is also:

- Affiliated with a **hospital** under a contractual agreement with an established system for patient referral
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations
- Licensed as a **chemical dependency** treatment program by an agency of the state of Texas having legal authority to so license, certify, or approve
- Licensed, certified, or approved as a **chemical dependency** treatment program or center by any other state agency having legal authority to so license, certify, or approve

Claim means notification in a form acceptable to us that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex,

identification number, the name and address of the **provider**, an itemized statement of the service rendered or furnished (including appropriate codes), the date of the service, the diagnosis (including appropriate codes), the **claim charge**, and any other information which we may request in connection with services rendered to you.

Claim Charge means the amount which appears on a **claim** as the **provider's** charge for services rendered to you, without adjustment or reduction and regardless of any separate financial arrangements between us and a particular **provider**.

Claim Payment means the **benefit** payment calculated by Blue Cross and Blue Shield, after submission of a **claim**, in accordance with the **benefits** described in this **policy**. All **claim payments** will be calculated on the basis of the **allowable amount** for **covered services** rendered to you, regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular **provider**. (See provisions of this **policy** regarding *"Blue Cross and Blue Shield's Separate Financial Arrangements with Providers."*)

Coinsurance means a percentage of an eligible expense that you are required to pay towards a **covered expense**.

Company means Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (also referred to herein as "BCBSTX").

Complications of Pregnancy means:

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

Copayment means a fixed dollar amount that you must pay before **benefits** are payable under this **policy**.

Covered Accident means an **accident** that occurs while your coverage is in force and results in a loss or **injury** covered by this **policy** for which **benefits** are payable.

Covered Expenses means expenses actually incurred by or on behalf of you for treatment, services and supplies not excluded or limited by this **policy**. Coverage under this **policy** must remain continuously in force from the date the **accident** or **sickness** occurs until the date treatment, services or supplies are received for them to be a **covered expense**. A **covered expense** is deemed to be incurred on the date such treatment, service, or supply, which gave rise to the expense or the charge, was rendered or obtained.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths
- Incision and drainage of facial abscess
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses
- Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the **plan**
- Removal of complete bony impacted teeth

Covered Person means any eligible **student** or an eligible **dependent** who applies for coverage, and for whom the required premium is paid.

Covered Service means a service or supply specified in this **policy** for which **benefits** will be provided.

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a **crisis stabilization unit or facility** for the provision of **behavioral health** services to you while you are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

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

Deductible means the dollar amount of **covered expenses** that must be incurred as an **out-of-pocket** expense by each **covered person** on a **policy** term basis before **benefits** are payable under this **policy**.

Dependent means:

- Your lawful spouse
- Your child(ren)

“Child(ren)” used hereafter in this **policy**, means a natural child(ren), a stepchild(ren), foster child(ren), adopted child(ren), (including a child(ren) for whom you are a party in a suit in which the adoption of the child(ren) is sought), a child(ren) of your child(ren), grandchild(ren), child(ren) for whom you are the legal guardian under 26 years of age, regardless of presence or absence of a child’s financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors.

Coverage will continue for a child who is 26 or more years old, chiefly supported by the **insured** and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child’s condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a child for the reasons listed above. During the next two years, we may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year.

Doctor means a **doctor** licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which their services are rendered and acting within the scope of that license or certificate. It will not include you or a member of your **immediate family** or household.

Drug List means a list of drugs that may be covered under the OUTPATIENT PRESCRIPTION DRUG PROGRAM section of this **policy**. This list is available by accessing the website at www.bcbstx.com. You may also contact Customer Service at the toll-free telephone number on the back of your identification card for more information. BCBSTX will routinely review the **drug list** and periodically adjust it to modify the preferred or non-preferred drug 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 you.

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

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

Services provided in an emergency room that are not **emergency care** may be excluded from emergency coverage, although these services may be covered under another **benefit**, if applicable. Non-**emergency services** provided in an emergency room for treatment of **behavioral health** will be paid the same as **emergency care** services.

Emergency Services means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a **hospital**, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and within the capabilities of the staff and facilities available at the **hospital**, such further medical examination and treatment as are required to stabilize the patient.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) 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
- The **physician** or **professional other provider** has had the appropriate training and experience to provide the treatment or procedure

The medical staff of BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is **experimental/investigational**, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination. Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational**.

Although a **physician** or **professional other provider** may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, BCBSTX still may determine such services or supplies to be **experimental/investigational** within this definition. Treatment provided as part of a clinical trial or a research study is **experimental/investigational**.

Extended Care Expenses means the **allowable amount** of charges incurred for those **medically necessary** services and supplies provided by a skilled nursing facility, a coordinated home health agency, or a hospice as described in the ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS section of this **policy**.

Family Coverage means coverage for you and your eligible spouse and/or **dependents** under this **policy**.

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

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 **prescription drugs** and corresponding payment level, Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized **provider** of drug product database information. A list of **generic drugs** is available by accessing the website at www.bcbstx.com. You may also contact Customer Service at the toll-free telephone number on the back of your identification card for more information.

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

Health 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.

Hearing Aid means any wearable non-disposable, non-experimental instrument or device designed to aid or compensate for impaired human hearing and any parts, attachments, or accessories for the instrument or device, including ear molds. This also includes Cochlear Implants.

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:

- Drugs and IV solutions
- **Pharmacy** compounding and dispensing services
- All equipment and ancillary supplies necessitated by the defined therapy
- Delivery services
- Patient and family education
- 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.

Hospital means a short-term acute care facility which:

- 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
- Is primarily engaged in providing **inpatient** diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **physicians** or **behavioral health practitioners** for compensation from its patients
- 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
- Provided 24-hour nursing services by or under the supervision of a registered nurse
- Has in effect a **hospital** utilization review plan

Hospital also means a licensed alcohol and drug abuse rehabilitation facility or a mental **hospital**. Alcohol and drug abuse rehabilitation facilities and mental **hospitals** are not required to provide organized facilities for major **surgery** on the premises on a prearranged basis.

Hospital Confined means a stay as a registered bed patient in a **hospital**. If you are admitted to and discharged from a **hospital** within a 24-hour period but are confined as a bed patient for the duration of your stay in the **hospital**, the admission shall be considered a **hospital confinement**.

Iatrogenic Infertility means an impairment of fertility caused directly or indirectly by **surgery,** chemotherapy, radiation, or other medical treatment, affecting reproductive organs or processes.

Immediate Family means your parent, spouse, child, brother, or sister.

Injury means accidental bodily harm sustained by you that results directly and independently from all other causes from a **covered accident**. The **injury** must be caused solely through external, violent, and accidental means. All **injuries** sustained by one person in any one **accident**, including all related conditions and recurrent symptoms of these **injuries**, are considered a single **injury**.

Inpatient means that you are a registered bed patient and are treated as such in a health care facility.

Institution means an **institution** of higher education as defined in the Higher Education Act of 1965.

Insured means a person in a class of eligible persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An **insured** is not a **dependent** covered under this **policy**.

Interscholastic Activities means playing, participating, and/or traveling to or from an interscholastic, intercollegiate, club sport, professional, or semi-professional sport, contest, or competition, including practice or conditioning for such activity.

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

Medical Care means the ordinary and usual professional services rendered by a **physician** or other specified **provider** during a professional visit for treatment of an illness or **injury**.

Medically Necessary or Medical Necessity means those services or supplies covered under this **policy** which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, **sickness**, disease, **injury**, or bodily malfunction
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States
- Not primarily for the convenience of you, your **physician**, **behavioral health practitioner**, the **hospital**, or the **other provider**
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of you. When applied to hospitalization, this further means that you require acute care as a bed patient due to the nature of the services provided or your condition, and you cannot receive safe or adequate care as an **outpatient**
- If more than one health intervention meets the requirements listed above, **medically necessary** means the most cost effective in terms of type of intervention or setting, frequency, extent, or duration, which is safe and effective for the patient's illness, **injury**, or disease and supports improved health.

The medical staff of BCBSTX shall determine whether a service or supply is **medically necessary** under the **plan** and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a **physician**, **behavioral health practitioner** or **professional other provider** may have prescribed treatment, such treatment may not be **medically necessary** within this definition.

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

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system as used by BCBSTX, whether the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin
2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a **physician**, **behavioral health practitioner** or **professional other provider** (or by any person working under the direction or supervision of a **physician**, **behavioral health practitioner** or **professional other provider**) when the covered expense is:
    - Individual, group, family, or conjoint psychotherapy

- Counseling
- Psychoanalysis
- Psychological testing and assessment
- The administration or monitoring of psychotropic drugs
- **Hospital** visits or consultations in a facility listed in subsection 5, below

3. Electroconvulsive treatment
4. Psychotropic drugs
5. Any of the services listed in subsections 1 through 4, above, performed in or by a **hospital**, **facility other provider**, or other licensed facility or unit providing such care

Network Pharmacy means an independent retail **pharmacy**, chain of retail **pharmacies**, mail-order **pharmacy**, or **specialty drug pharmacy** which has entered into a written agreement with BCBSTX to provide pharmaceutical services to you under this **policy**.

Network Provider means a **hospital**, **doctor** 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**.

Non-Preferred Brand Name Drug means a **brand name drug** which appears on the **drug list** as a **non-preferred brand name drug** and is subject to the **non-preferred brand name drug copayment**. The **drug list** is available by accessing the website at www.bcbstx.com.

Non-Preferred Generic Drug means a **generic drug** which appears on the **drug list** as a **non-preferred generic drug** and is subject to the **non-preferred generic drug copayment**. The **drug list** is available by accessing the website at www.bcbstx.com.

Non-Preferred Specialty Drug means a **specialty drug** which appears on the **drug list** as **non-preferred specialty drug** and is subject to the **non-preferred specialty drug copayment**. The **drug list** is available by accessing the website at www.bcbstx.com.

Other Provider means a person or entity, other than a **hospital** or **physician**, which is licensed where required to furnish to you an item of service or supply described herein as eligible expenses. **Other provider** shall include:

- **Facility Other Provider** - an institution or entity, only as listed:
  - **Chemical dependency treatment center**
  - **Crisis stabilization unit or facility**
  - Durable medical equipment **provider**
  - Home health agency
  - **Home infusion therapy provider**
  - Hospice
  - Imaging center
  - Independent laboratory
  - Prosthetics/orthotics **provider**
  - **Psychiatric day treatment facility**
  - Renal dialysis center
  - Residential treatment center for children and adolescents

- Skilled nursing facility
- Therapeutic center

- **Professional Other Provider** - a person or practitioner, when acting within the scope of their license and who is appropriately certified, only as listed:
  - Advanced Practice Nurse
  - **Doctor** of Chiropractic
  - **Doctor** of Dentistry
  - **Doctor** of Optometry
  - **Doctor** of Podiatry
  - **Doctor** in Psychology
  - Licensed Acupuncturist
  - Licensed Audiologist
  - Licensed Chemical Dependency Counselor
  - Licensed Dietitian
  - Licensed Hearing Instrument Fitter and Dispenser
  - Licensed Marriage and Family Therapist
  - Licensed Clinical Social Worker
  - Licensed Occupational Therapist
  - Licensed Physical Therapist
  - Licensed Professional Counselor
  - Licensed Speech-Language Pathologist
  - Licensed Surgical Assistant
  - Nurse First Assistant
  - Physician Assistant
  - Psychological Associates who work under the supervision of a **Doctor** in Psychology

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

Out-of-Network Provider means a **hospital**, **doctor** or **other provider** who has not entered into an agreement with BCBSTX (or other participating Blue Cross and Blue Shield Plan) as a managed care **provider**.

Out-of-Pocket Maximum means the maximum liability that may be incurred by you in a **benefit period** before **benefits** are payable at 100% of the **allowable amount**.

Outpatient means that you are receiving treatment while not an **inpatient**. Services considered **outpatient** include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an **inpatient** in a health care facility.

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 they practice.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the Physicians' Current Procedural Terminology Manual, whether the service or supply is provided by a **physician** or **professional other provider**, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

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

Plan means Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association issued group **benefits** contract.

Policy means this **policy** issued by Blue Cross and Blue Shield to the **institution**, any addenda, the **institution**'s application for Blanket Student Accident and Sickness Health Insurance, your application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

Preferred Brand Name Drug means a **brand name drug** that is identified as a **preferred brand name drug** on the **drug list** and is subject to the **preferred brand name drug copayment**. The **drug list** is available by accessing the website at www.bcbstx.com.

Preferred Generic Drug means a **generic drug** that is identified as a **preferred generic drug** on the **drug list** and is subject to the **preferred generic drug copayment**. The **drug list** is available by accessing the website at www.bcbstx.com.

Preferred Specialty Drug means a **specialty drug** that is identified as a **preferred specialty drug** on the **drug list** and is subject to the **preferred specialty drug copayment**. The **drug list** is available by accessing the website at www.bcbstx.com.

Prescription Drugs means:

- Prescription legend drugs
- Compound medications of which at least one ingredient is a prescription legend drug
- **Prescription drugs** that have been approved by the FDA for one protocol will be covered when found to be effective and prescribed for another
- Any other drugs that under the applicable state or federal law may be dispensed only upon written prescription of a **doctor**

Prescription drugs will also include FDA approved female contraceptive drugs and devices and **outpatient** contraceptive services.

Prescription Order means a written or verbal order from a **health care practitioner** to a pharmacist for a drug to be dispensed. Orders written by a **health care practitioner** located outside the United States to be dispensed in the United States are not covered under this **policy**.

Prior Authorization means the process that determines in advance the **medical necessity** or **experimental/investigational** nature of certain care and services under this **policy**.

Provider means a **hospital**, **physician**, **behavioral health practitioner**, **other provider**, or any other person, company, or institution furnishing to you an item of service or supply listed as **covered expenses**.

Psychiatric Day Treatment Facility means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a **psychiatric day treatment facility** for the provision of **mental health care** and **serious mental illness** services to you for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a **psychiatric day treatment facility** must be certified in writing by the attending **physician** or **behavioral health practitioner** to be in lieu of hospitalization.

Qualifying Intercollegiate Sport means a sport: (1) which is not an interscholastic activity (as defined in this **policy**); (2) which is administered by such **institution's** department of intercollegiate athletics; and (3) for which **benefits** for **covered accidents** are provided for and payable under this **policy** while you are playing, participating, and/or traveling to or from an intercollegiate sport, contest, or competition, including practice or conditioning for such activity.

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

Rescission means a cancellation or discontinuance of coverage that has retroactive effect except to the extent attributable to a failure to timely pay premiums.

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

- Bipolar disorders (hypomanic, manic, depressive, and mixed)
- Depression in childhood and adolescence
- Major depressive disorders (single episode or recurrent)
- Obsessive-compulsive disorders
- Paranoid and other psychotic disorders
- Schizoaffective disorders (bipolar or depressive)
- Schizophrenia

Sickness means an illness, disease, or condition that causes a loss for which you incur medical expenses while covered under this **policy**. All related conditions and recurrent symptoms of the same or similar condition will be considered one **sickness**.

Specialty Drugs means **prescription drugs** generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are high-cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of **specialty drugs** is subject to change. To determine which drugs are **specialty drugs**, you should contact your **pharmacy**, refer to the **drug list** by accessing the website at www.bcbstx.com/tx/documents/rx-drugs/specialty-drug-list-tx.pdf or contact Customer Service at the telephone number on the back of your identification card.

Specialty Pharmacy means a participating **prescription drug** provider that has a written agreement with Blue Cross and Blue Shield of Texas, or the entity chosen by Blue Cross and Blue Shield of Texas, to administer its **prescription drug** program to provide **specialty drugs** to you.

Student means an individual **student** who meets the eligibility requirements for this health coverage, as described in the eligibility requirements of this **policy**.

Student Administrative Health Fee means a fee charged by the **institution** on a periodic basis to **students** of the **institution** to offset the cost of providing health care through health clinics regardless of whether the **students** utilize the health clinics or enroll in student health insurance. **Student administrative health fees** are not considered **deductibles**, **copayments**, **coinsurance**, or other cost sharing for purposes of preventive care services **benefits**, and do not count toward maximums.

Surgery means the performance of any medically recognized, non-**experimental/investigational** surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations, and any other procedures as reasonably approved by Blue Cross and Blue Shield of Texas.

Teledentistry means services delivered by a dentist or health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient via telephone or other similar technology.

Telehealth means a health service, other than a **telemedicine** medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional via telephone or similar technology.

Telemedicine means a health care service delivered by a **physician** licensed in Texas, or a health professional acting under the delegation and supervision of a **physician** licensed in the state of Texas and acting within the scope of the **physician's** or health professional's license to a patient at a different physical location than the **physician** or health professional via telephone or similar technology.

We, Our, Us means Blue Cross and Blue Shield of Texas or its authorized agent.

EFFECTIVE DATE OF COVERAGE

Coverage for an eligible person who enrolls during this **policy's** enrollment period, as established by the **institution**, is effective on the latest of the following dates:

- The **policy** effective date
- The date we receive the completed online enrollment form
- The date after the required premium is paid
- The date you enter the eligible class

Your eligible **dependent** who enrolls: (1) during the enrollment period established by the **policyholder**; (2) within 31 days after you acquire a new **dependent**; or (3) within 31 days after a **dependent** terminates coverage under another health care plan is effective on the latest of the following dates:

- The first day of the coverage period
- The date you enter the eligible class
- The date we receive the completed online enrollment form
- The date after the required premium is paid

After the time periods described above, you or your **dependent** must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another health care plan.

We will pay **benefits** for your newborn child until that child is 60 days old. Coverage may be continued beyond the 60 days if you notify us of the child's birth and pay the required premium, if any.

Adopted children, as defined by this **policy**, will be covered on the same basis as a newborn child from the date you becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and your legal obligation terminates.

Coverage for newborn and adopted children will consist of coverage for covered **injury** or covered **sickness** including the necessary care and treatment of medically diagnosed congenital defects, prematurity, well baby care, birth abnormalities, administration of a newborn screening test (which includes the test kit, required by the state of Texas), and routine nursery care related to a covered **sickness**.

Open Enrollment Periods

The **institution** will designate open enrollment periods during which you may apply for or change coverage for yourself and/or your eligible spouse and/or **dependents**.

This OPEN ENROLLMENT PERIODS section is subject to change by Blue Cross and Blue Shield of Texas, and/or applicable law, as appropriate.

Qualifying Event

Eligible **students** and eligible **dependents** who have a change in status and lose coverage under another health care plan, are eligible to enroll for coverage under this **policy**. Within 31 days of the qualifying event, you or your **dependent** must complete supporting documentation. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, or annulment, gain of a **dependent** whether by birth, adoption, suit for adoption, or court-ordered **dependent** coverage, or loss of **dependent** status because of age. The premium will be prorated based

on what it would have been at the beginning of the semester or quarter, whichever applies. However, the effective date will be the later of the date you or your **dependent** enroll for coverage under this **policy** and pay the required premium, or the day after the prior coverage ends. Please contact your **institution** for further information.

DISCONTINUANCE OF INSURANCE

Termination Date Of Insurance

Your coverage will end on the earliest of the date:

- This **policy** terminates
- You are no longer eligible
- The period ends for which premium is paid

A **dependent's** coverage will end on the earliest of the date:

- They are no longer a **dependent**
- Your coverage ends
- The period ends for which premium is paid
- This **policy** terminates

Refund Of Premium

A refund of premium will be made only in the event:

- Of your death
- You enter full-time active duty in any Armed Forces and we receive proof of such active-duty service

Extension Of Benefits

If you are confined in a **hospital** for a medical condition on the date your coverage under this **policy** is terminated, expenses incurred during the continuation of that **hospital** stay will be considered a covered expense, but only while such expenses are incurred during the 90 day period following the termination of insurance. We will not continue to pay these covered expenses if:

- Your medical condition no longer continues
- You reach any maximum that may apply
- You obtain other coverage
- The **covered expenses** are incurred more than 3 months following termination of insurance

Continuation Of Coverage

A **covered person** who has been insured under this **policy** may continue to be insured under this **policy** when coverage terminates subject to the following:

- Continuation of coverage is available to **students** and their covered **dependents**, when you leave school, die, or when your covered **dependent** no longer qualifies as an eligible **dependent**.
- The **covered person** requesting coverage must have been insured under this **policy** for at least 4 months.

Requests for continuation of coverage, with the applicable premium, must be submitted within 30 days of:

- The date the existing coverage would otherwise terminate
- The date the **covered person** is notified of the right to continue the coverage

Coverage and **benefits** will be the same as those which are applicable prior to continuation.

Premium rates for continuation of coverage may be higher than **student** rates.

The maximum period for which coverage may be continued is 3 months.

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

We will pay the **covered expenses** as shown in the SCHEDULE OF BENEFITS if you require treatment by a **doctor**. We will consider the **allowable amount** incurred for **medically necessary covered expenses**. **Benefit** payments are subject to the **deductibles**, **copayments** and **coinsurance** shown in the SCHEDULE OF BENEFITS, and **benefit** maximums, if any, shown in the **benefit** description as well as any other terms, conditions, limitations, or exclusions described in this **policy**.

Covered Expenses

Hospital Expenses

- Daily room and board at semi-private room rate when **hospital confined**
- General nursing care provided and charged for by the **hospital**
- Intensive care: we will make this payment in lieu of the semi-private room expenses.
- Coordinated home care **benefits** following **hospital confinement**
- Hospital Miscellaneous Expenses: expenses incurred while **hospital confined** or as a precondition for being **hospital confined**, for services and supplies such as the cost of operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, physical therapy, therapeutic services, and supplies. In computing the number of days payable under this **benefit**, the date of admission will be counted but not the date of discharge.
- Surgical Expense: Surgeon's fees for **inpatient surgery** paid as shown in the SCHEDULE OF BENEFITS. If an **injury** or **sickness** requires multiple surgical procedures, we will cover according to the **allowable amount** shown in the SCHEDULE OF BENEFITS.
- Preadmission testing: when **medically necessary**, in connection with **inpatient surgery**
- Assistant Surgeon Services: when **medically necessary**, in connection with **inpatient surgery**
- Anesthetist Services: in connection with **inpatient surgery**
- Doctor's Visits: when **hospital confined**. **Benefits** do not apply when related to **surgery** and will be paid as a covered **inpatient** expense as shown in the SCHEDULE OF BENEFITS.
- Staff nursing care while confined to a **hospital** by a licensed registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN)

Outpatient Expenses

- Day **Surgery**/**Outpatient** Surgical Expense: Surgeon's fees for **outpatient surgery** paid as shown in the SCHEDULE OF BENEFITS. If an **injury** or **sickness** requires multiple surgical procedures, we will cover according to the **allowable amount** shown in the SCHEDULE OF BENEFITS.
- Day **Surgery** Miscellaneous Expenses: Services related to scheduled **surgery** performed in a **hospital** or ambulatory surgical center, including operating room expenses, laboratory tests and diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines; therapeutic services and supplies. **Benefits** will not be paid for **surgery** performed in a **hospital** emergency room, **doctor's** office, or clinic.
- Preadmission Testing: when **medically necessary**, in connection with **outpatient surgery**

- Assistant Surgeon Services: when **medically necessary**, in connection with **outpatient surgery**
- Anesthetist Services: in connection with **outpatient surgery**
- **Doctor's** Visits: **Benefits** will be paid as shown in the SCHEDULE OF BENEFITS. **Doctor** visits related to **surgery** will not be subject to a **copayment** and will be paid as an **outpatient** expense as shown in the SCHEDULE OF BENEFITS.
- **Home Infusion Therapy** will be paid as shown in the SCHEDULE OF BENEFITS.
- **Habilitation Services**: includes, but is not limited to, physical, occupational, speech therapy evaluations and services, dietary or nutritional evaluations, and manipulative therapy. **Benefits** for **habilitation services** will be limited to 35 visits per **benefit period**. Therapies associated with developmental delays will not be limited to annual or lifetime maximums.
- **Rehabilitation Services**: includes, but is not limited to, physical, occupational, speech therapy evaluations and services, dietary or nutritional evaluations, and manipulative therapy. **Benefits** for **rehabilitation services** will be limited to 35 visits per **benefit period**. Therapies associated with developmental delays will not be limited to annual or lifetime maximums.
- Diagnostic X-ray and Laboratory Services: when **medically necessary** and performed by a **doctor** will include diagnostic services and medical procedures performed by a **doctor**, other than **doctor's** visits, X-Ray and lab procedures
- Medical Emergency Expenses: only in connection with **emergency care** as defined. **Benefits** will be paid as shown in the SCHEDULE OF BENEFITS for the use of the emergency room and supplies.
- Urgent Care
- Radiation & Chemotherapy
- Allergy Injections and Allergy Testing

Other Expenses

- Ambulance Service: Payment will be made to the **provider** as shown in the SCHEDULE OF BENEFITS.
- Consultant **Doctor** Fees: when requested and approved by the attending **doctor**
- We will pay the actual expenses incurred, including **medically necessary** maternity testing, as a result of pregnancy, childbirth, miscarriage, or any **complications of pregnancy**. **Benefits** will also cover a period of hospitalization for maternity and newborn infant care for:
    - A minimum of 48 hours of inpatient care following a vaginal delivery
    - A minimum of 96 hours of inpatient care following delivery by cesarean section

  Your **provider** will not be required to obtain **prior authorization** from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours).

  If the **doctor**, in consultation with the **covered person**, determines that an early discharge is medically appropriate, We shall provide coverage for post-delivery care, within the above time limits, to be delivered in your home, or in a **provider's** office, as determined by the **doctor** in consultation with the **covered person**. The at-home post-delivery care shall be provided by a registered professional nurse, **doctor**, nurse practitioner, nurse midwife, or **physician's**

assistant experienced in maternal and child health, and shall include:
    - Parental education
    - Assistance and training in breast or bottle feeding
    - Performance of any **medically necessary** and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening

- Routine Well-Baby Care: while the baby is **hospital confined** and for routine nursery care provided within the first 31 days after birth, including treatment of diagnosed congenital and birth abnormalities
- Dental treatment (**injury** Only): when performed by a **doctor** and made necessary by **injury** to sound, natural teeth. If there is more than one way to treat a dental problem, we will pay based on the least expensive procedure if that procedure meets commonly accepted dental standards of the American Dental Association.
- **Covered oral surgery**
- Tests and Procedures: diagnostic services and medical procedures performed by a **doctor** other than **doctor's** visits, physical therapy and X-Rays and lab procedures
- Treatment for loss or impairment of speech or hearing: **Benefits** will be paid for incurred expenses the same as for treatment of any other **sickness** subject to the **hearing aid** maximum specified below.
- Hearing Aids: **Benefits** for **covered expenses** incurred for services to restore the loss of, or correct an impaired speech or hearing function, with **hearing aids** will be the same as any other **sickness**. Limited to one **hearing aid** per ear each 36-month period
- Screening for Early Detection Tests for Cardiovascular Disease: **Benefits** will be paid for noninvasive screening tests for atherosclerosis and abnormal artery structure and function when performed by a laboratory that is certified by a recognized national organization as shown in the SCHEDULE OF BENEFITS:
    - Computed tomography (CT) scanning measuring coronary artery calcifications
    - Ultrasonography measuring carotid intima-media thickness and plaque
- Skilled Nursing Facility: subject to the **prior authorization** guidelines set forth in this **policy** and limited to a maximum of 25 days per **benefit period**
- Coordinated Home Health Care: subject to the **prior authorization** guidelines set forth in this **policy** and limited to a maximum of 60 visits per **benefit period**
- Hospice: subject to the **prior authorization** guidelines set forth in this **policy**
- Treatment of Chemical Dependency: **Benefits** for covered expenses incurred for the treatment of **chemical dependency** will be the same as for treatment of any other **sickness**, subject to the **prior authorization** guidelines set forth in this **policy**. **Mental health care** provided as part of the **medically necessary** treatment of **chemical dependency** will be considered for **benefit** purposes to be treatment of **chemical dependency** until completion of **chemical dependency** treatments. (**Mental health care** treatment after completion of **chemical dependency** treatments will be considered **mental health care**.)

- Serious Mental Illness: **Benefits** for **covered expenses** incurred for the treatment of **serious mental illness** will be the same as for treatment of any other **sickness**, subject to the **prior authorization** guidelines set forth in this **policy**.
- Mental Health Care: **Benefits** for **covered expenses** incurred for the treatment of **mental health care** will be the same as for treatment of any other **sickness**, subject to the **prior authorization** guidelines set forth in this **policy**.
- Adult Vision Exam: **Benefits** for an annual routine adult vision exam, for age 19 and over, are covered subject to the same **deductibles**, **copayments**, and **coinsurance** as for services and supplies generally.

Acquired Brain Injury

Coverage is provided for the following services necessary as a result of, and related to, an acquired brain **injury**:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment
- Neurofeedback therapy
- Remediation, post-acute transition services, and community reintegration services, including **outpatient** day treatment services or other post-acute care treatment

Such services may be provided a **hospital**, including an acute or post-acute rehabilitation **hospital**, or an assisted living facility as regulated by the state.

For purposes of this section, post-acute care will include coverage for the reasonable expenses related to periodic re-evaluation of the **plan** for a **covered person** with an acquired brain **injury** who:

- Has been unresponsive to treatment
- Becomes responsive at a later date

Determination of whether such post-acute care expenses are reasonable will include consideration of factors including:

- Cost
- The time elapsed since the prior evaluation
- Differences in the expertise of the **provider** performing the evaluation
- Changes in technology and advances in medicine

Benefits for acquired brain **injury** will not be subject to any visit limit indicated on your SCHEDULE OF BENEFITS. For purposes of this provision, the following words and terms have these meanings:

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

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

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

Community reintegration services are services that facilitate the continuum of care as an affected individual's transitions into the community including **outpatient** day treatment services or other post-acute care treatment services.

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

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

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

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

Neurophysiological testing is an evaluation of the functions of the nervous system.

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

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

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

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

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

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

Psychophysiological testing is an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

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

Benefits will be payable on the same basis as any other illness and subject to all provisions and limitations of this **policy**.

Autism Spectrum Disorders

Coverage is provided under this **policy** for **covered expenses** incurred for treatment of a covered child who has been diagnosed with Autism Spectrum Disorder. Treatment will include generally recognized services contained in a treatment plan recommended by the child's primary **doctor**. Such services will include but are not limited to:

- Evaluation and assessment services
- Applied behavior analysis
- Behavior training and management
- Speech, physical, and occupational therapy
- Medications or nutritional supplements used to address symptoms of the Autism Spectrum Disorder

Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or other non-specific pervasive developmental disorders.

Neurobiological disorder means an **illness** of the nervous system caused by genetic, metabolic, or other biological factors.

Benefits will be payable to the same extent as for covered medical expenses for any other covered **illness** and subject to all of the terms and conditions of this **policy** not to the contrary.

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available 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 **covered person** under the **plan** who is at least:

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

Biomarker Testing

Benefits will be provided for **medically necessary biomarker testing** for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition to guide treatment when the test is supported by medical and scientific evidence, including:

- A labeled indication for a test approved or cleared by the FDA
- An indicated test for a drug approved by the FDA
- A national coverage determination made by CMS, or a local coverage determination made by a Medicare administrative contractor
- Nationally recognized clinical practice guidelines
- Consensus statements

Biomarker testing will be covered only when use of **biomarker testing** provides clinical utility because use of the test for the condition is evidence-based, is scientifically valid based on the medical and scientific evidence, informs your outcome and a **provider's** clinical decision, and predominantly addresses the acute or chronic issue for which the test is ordered.

Breast Reconstructive Surgery after Mastectomy

Your **policy** as required by the federal Women's Health and Cancer Rights Act of 1998, provides **benefits** for mastectomy-related services. If you are eligible for mastectomy **benefits** under this **policy** and you elect breast reconstruction in connection with such mastectomy, you are also covered for the following:

- Reconstruction of the breast on which the mastectomy has been performed
- **Surgery** and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment for physical complications of all stages of mastectomy, including lymphedemas

Coverage for breast reconstructive **surgery** may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the **policy** definition of **medically necessary**.

Benefits will be payable on the same basis as any other **sickness** or **injury** under this **policy**, including the application of appropriate **deductibles**, **copayments**, and **coinsurance**.

Child Hearing Tests and Immunizations

Coverage is provided for a screening test for hearing loss for a child from the date of birth through the date the child is 31 days old and any necessary diagnostic follow-up care related to such screening test through the date the child is 24 months old.

Coverage is also provided for the vaccine and administration charges for the following immunizations: diphtheria, Haemophilus influenza type b (Hib), hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization that is required by law for the child.

Child immunizations will be provided for covered **dependents** from the date of birth through age 6.

Benefits for immunizations will be subject to all of the terms and conditions of this **policy** except that no **deductible**, **copayment**, or **coinsurance** will apply.

Clinical Trial Programs

Coverage will be provided under this **policy** for those **covered expenses** incurred by you while participating in a Phase I, II, III or IV clinical trial program for the detection, prevention, or treatment of cancer or a **life-threatening disease or condition** and is recognized under state and/or federal law.

Cochlear Implants

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

Craniofacial Abnormalities

Coverage will include the **medically necessary** expenses incurred for reconstructive **surgery** for craniofacial abnormalities for a **covered person**.

Reconstructive surgery for craniofacial abnormalitie*s* means **surgery** to improve the function of or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or diseases.

Benefits are payable to the same extent and subject to all conditions and limitations of this **policy** as apply to any other covered **sickness**.

Diabetes Coverage and Self-Management Education

Benefits will be paid for **covered expenses** incurred by you for **medically necessary** equipment and related supplies for the treatment of Type 1, Type 2, or gestational diabetes when prescribed by a **doctor** or other licensed health care **provider**.

Benefits for such charges will be payable on the same basis as any other **sickness** under the **policy**.

Equipment and related supplies which may be **medically necessary** include, but are not limited to, the following:

- Blood glucose monitors, including blood glucose monitors for the visually impaired, noninvasive glucose monitors, and monitor test strips
- Visual and urine testing strips and tablets, lancets and lancet devices, injection aids, and syringes
- Biohazard disposal containers
- Insulin and insulin analog preparations
- **Prescription drugs** and medications available without prescription for the controlling of blood sugar levels
- Insulin pumps, external and implantable, and equipment and supplies for the use of the pump including:
    - Batteries
    - Insulin infusion devices and infusion sets
    - Insulin cartridges and durable and disposable devices for the injection of insulin
    - Skin preparation items and adhesive supplies
- Repairs and necessary maintenance of insulin pumps not otherwise provided by manufacturer's warranty or purchase agreement. This will include the rental fee for pumps during repair or necessary maintenance; however, such fees will not exceed the purchase price of a similar replacement pump.
- Podiatric appliances and therapeutic footwear
- Glucagon emergency kits

Coverage is also provided for the regular foot care exams of a diabetic patient when provided by a **doctor**.

All supplies, including medications and equipment for the control of diabetes will be dispensed as written, unless substitution is approved by the **doctor** or health care **provider** who issued the written order.

Benefits are payable on the same basis as any other covered **sickness** under this **policy**.

Benefits are payable for **covered expenses** incurred for a program of instruction in the self-care of diabetes that enables a diabetic to understand the disease and to manage its daily therapy when prescribed by a **doctor** or other health care **provider**.

Diabetes self-management training including medical nutritional therapy may be conducted individually or in a group; but it must be provided by a **doctor** or certified, registered, or licensed health care professional with expertise in diabetes. Coverage will include all educational materials for such program.

Diabetic self-management education **benefits** are payable to the same extent as any other covered **sickness** and subject to all of the terms and conditions of this **policy**.

Diagnostic Breast Imaging

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

- A subjective or objective abnormality detected by a **physician** or patient in a breast
- An abnormality seen by a **physician** on a screening mammogram
- An abnormality previously identified by a **physician** as probably benign in a breast for which follow-up imaging is recommended by a **physician**
- An individual with a personal history of breast cancer or dense breast tissue. Diagnostic imaging **benefits** will be the same as screening mammograms.

Durable Medical Equipment

Prosthetic Appliances, Braces, and **medically necessary** services related to the fitting and use of these devices when prescribed by a **doctor** and a written prescription accompanies the **claim** when submitted. Replacement or repairs to braces and appliances are covered unless the repair or replacement is necessitated by misuse or loss by you. Durable medical equipment is equipment that:

- Is primarily and customarily used to serve a medical purpose
- Can withstand repeated use
- Generally, is not useful to person in the absence of **injury**

No **benefits** will be paid for rental charges in excess of the purchase price.

Prosthetic Appliance 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.

Orthotic Device means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Covered services are limited to the most appropriate model of Prosthetic Appliance or Orthotic Device that adequately meets the medical needs of the **covered person** as determined by the **covered person's** treating **physician**, podiatrist, prosthetist, or orthotist as applicable.

Coverage may be subject to annual **deductibles**, **copayments** and **coinsurance** that are consistent with those for other coverage under this **policy** and may not be subject to annual dollar maximums.

The following are covered equipment examples:

- Wheelchair, cane, crutches, walker, ventilator, oxygen tank
- Mandibular reconstruction devices
- Internal cardiac valves, internal pacemakers
- External heart monitors (cardiac event detection monitoring device)

The following are examples of non-covered equipment:

- Modifications to home or vehicle such as: vehicle lifts or stair lifts
- Biofeedback equipment
- Computer assisted communication devices
- Home spirometers or telespirometers
- Replacement of lost or stolen durable medical equipment
- Personal comfort, hygiene or convenience items such as support garments and air purifiers
- Physical fitness equipment

Elemental Formulas

Coverage is provided under this **policy** for the **covered expenses** incurred for amino acid-based elemental formulas. Such formulas must be upon written order of a **doctor** and **medically necessary** for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
- Severe food protein induced enterocolitis syndrome
- Eosinophilic disorders as evidenced by a biopsy
- Impaired absorption of nutrients due to disorders of the gastrointestinal tract

Coverage will also be provided for any **medically necessary** medical services associated with the administration of these formulas.

Benefits will be provided to the same extent as for any other covered medical services and subject to all of the terms and conditions of this **policy** as apply to any other covered **sickness**.

Fertility Preservation Services

Benefits for fertility preservation services for **covered persons** who will receive **medically necessary** treatment which may directly or indirectly cause Iatrogenic Infertility.

The fertility preservation services must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Fertility preservation services means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue, and does not include the storage of such unfertilized genetic materials.

Inheritable Metabolic Disorders

Coverage is provided for enteral formulas necessary for the treatment of Phenylketonuria or other inheritable metabolic disorders. **Benefits** are the same as provided for any other **prescription drug** and subject to all of the terms and conditions of this **policy**.

Injectable Drugs

Benefits are available for **medically necessary** injectable drugs which are self-administered that require a written prescription by federal law. **Benefits** will not be provided for any self-administered drugs dispensed by a **physician**.

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth **benefits**, we will provide **inpatient** care for the **covered person** and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by Cesarean section

This **benefit** does not require a **covered person** who is eligible for maternity/childbirth **benefits** to:

- Give birth in a **hospital** or other health care facility
- Remain in a **hospital** or other health care facility for the minimum number of hours following birth of the child

If a **covered person** or newborn child is discharged before the 48 hour or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breastfeeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. Care will be provided by a **physician**, registered nurse or other appropriately licensed health care **provider**, and the **covered person** will have the option of receiving the care at their home, the health care **provider's** office, or a health care facility.

Prohibitions: We may not:

- Modify the terms of this coverage based on you requesting less than the minimum coverage required
- Offer the **covered person** financial incentives or other compensation for waiver of the minimum number of hours required
- Refuse to accept a **physician's** recommendation for a specified period of **inpatient** care made in consultation with the **covered person** if the period recommended by the **physician** does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians, gynecologists, or pediatricians
- Reduce payments or reimbursements below the usual and customary rate
- Penalize a **physician** for recommending **inpatient** care for the **covered person** or the newborn child

Mastectomy or Lymph Node Dissection

Minimum **inpatient** stay: if due to treatment of breast cancer, any person covered by this **policy** has either a mastectomy or a lymph node dissection, this **policy** will provide coverage for a length of time determined by the attending **doctor** to be **medically necessary inpatient** care for a minimum of:

- 48 hours following a mastectomy
- 24 hours following a lymph node dissection

The minimum number of **inpatient** hours is not required if the individual receiving the treatment and the attending **physician** determine that a shorter period of **inpatient** care is appropriate. The length of time will be based on the evaluation of the patient and the availability of post-discharge **doctor's** office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

Benefits will be payable on the same basis as any other **sickness** under the **policy**.

Mastectomy means the surgical removal of all or part of a breast.

Prohibitions: We may not: (1) deny you eligibility or continued eligibility or fail to renew this **policy** solely to avoid providing the minimum **inpatient** hours; (2) provide money payments or rebates to encourage you to accept less than the minimum **inpatient** hours; (3) reduce or limit the amount paid to the attending **physician**, or otherwise penalize the **physician**, because the **physician** required you to receive the minimum **inpatient** hours; or (4) provide financial or other incentives to the attending **physician** to encourage the **physician** to provide care that is less than the minimum hours.

Medical Benefit Therapeutic Alternatives

Certain **prescription drugs** administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. **Benefits** may be limited to only certain therapeutic equivalents or therapeutic alternatives. However, **benefits** may be provided for the therapeutic equivalents or therapeutic alternatives that are not otherwise covered under your **benefit** if an exception is granted.

You may contact Customer Service at the toll-free telephone number on the back of your identification card or visit www.bcbstx.com/find-care/medical-rx for more information about covered therapeutic equivalents or therapeutic alternatives. To request an exception, you, your prescribing health care **provider**, or your authorized representative, can call the toll-free telephone number on the back of your identification card.

Therapeutic equivalents or therapeutic alternatives may be covered through your **prescription drug benefit**, depending on your **benefit** plan.

Orally Administered Anticancer Medication

Benefits are available for **medically necessary** orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. **Coinsurance** and/or **copayment** will not apply to certain orally administered anticancer medications. To determine if a specific drug is included in this **benefit**, you may contact Customer Service at the toll-free telephone number on the back of your identification card.

Organ and Tissue Transplants

Subject to the conditions described below, **benefits** for **covered services** and supplies provided to you 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:

- The transplant procedure is not **experimental/investigational** in nature
- Donated human organs or tissue or an FDA-approved artificial device are used
- The recipient is a **covered person** under this **policy**
- **Prior authorization** has been obtained for the transplant procedure as required under this **policy**
- The **covered person** meets all of the criteria established by BCBSTX in pertinent written medical policies
- The **covered person** 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.

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 recipient who is covered under this **policy**
- A donor who is a **covered person** under this **policy**
- A donor who is not a **covered person** under this **policy**

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

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

No **benefits** are available for a **covered person** for the following services or supplies:

- Living and/or travel expenses of the recipient or a live donor
- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation
- Purchase of the organ or tissue
- Organs or tissue (xenograft) obtained from another species
- If the transplant operation or post-transplant care is performed in China or another country known to have participated in forced organ harvesting
- If the human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting

Prior authorization is required for any organ or tissue transplant. Review the PRIOR AUTHORIZATION REQUIREMENTS section in this **policy** for more specific information about **prior authorization**.

Such specific **prior authorization** is required even if the patient is already a patient in a **hospital** under another **prior authorization**.

At the time **prior authorization** is obtained, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is **medically necessary**.

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

Prosthetic and Orthotic Devices

Coverage is provided for prosthetic devices, orthotic devices, and professional services related to the fitting and use of these devices.

Covered services are limited to the most appropriate model of prosthetic device or orthotic device that adequately meets your medical needs as determined by your treating **physician**, podiatrist, prosthetist, or orthotist as applicable.

Coverage may be subject to annual **deductibles**, **copayments** and **coinsurance** that are consistent with those for other coverage under this **policy** and may not be subject to annual dollar maximums.

Telehealth, Telemedicine, and Teledentistry Services

Coverage is provided for expenses incurred for **telehealth**, **telemedicine**, and **teledentistry** services as defined below.

Telehealth Services means a health service, other than a **telemedicine** medical service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telephone or similar technology.

Teledentistry Services means services delivered by a dentist or health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient via telephone or other similar technology.

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

Benefits are payable to the same extent as for any other covered medical service and subject to all of the terms and conditions of this **policy**.

Temporomandibular and Craniomandibular Joint Disorder Treatment Expense

Expenses for the **medically necessary** diagnosis or surgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD) as a result of an **accident**, a trauma, congenital defect, a developmental defect, or a pathology are covered to the same extent as any other skeletal disorder. Such expenses are subject to all provisions of this **policy** that apply to any other **sickness**.

PREVENTIVE CARE SERVICES

In addition to the **benefits** otherwise provided for in this **policy**, (and notwithstanding anything in this **policy** to the contrary), the following **benefits** for preventive care services will be considered **covered services** and will not be subject to any **deductible**, **coinsurance**, **copayment** or dollar maximum (to be implemented in the quantities and within the time period allowed under applicable law or regulatory guidance) when such services are received from a participating **provider** that is contracted for such service:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF")
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents
- With respect to women, such additional preventive care, and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA

For purposes of this **benefit** provision, the current recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention will be considered the most current (other than those issued in or around November 2009)

The preventive care services described above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the Blue Cross and Blue Shield website at www.bcbstx.com or contact Customer Service at the toll-free telephone number on the back of your identification card.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any **deductible**, **copayment**, **coinsurance**, or dollar maximum when obtained from a participating **pharmacy**. Drugs on the No-Cost Preventive Drug List that are obtained from a non-participating **pharmacy** may be subject to **deductible**, **copayments**, **coinsurance**, or dollar maximum, if applicable.

A **copayment** waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

If a recommendation or guideline for a particular preventive care service does not specify the frequency, method, treatment, or setting in which it much be provided, BCBSTX may use reasonable medical management techniques to apply coverage.

If a covered preventive care service is provided during an office visit and is billed separately from the office visit, you may be responsible for **deductible**, **copayments**, and/or **coinsurance** for the office visit only. If an office visit and the preventive care service are not billed separately and the primary purpose of the visit was not the preventive health service, you may be responsible for **deductible**, **copayments**, and/or **coinsurance**.

IMPORTANT

These services are free only when delivered by a network provider.

Preventive care services for adults (and others as specified)

- Abdominal aortic aneurysm one-time screening for men ages 65 to 75 who have ever smoked
- Aspirin use for men and women for prevention of cardiovascular disease and colorectal cancer for adults 45 to 59 with a high cardiovascular risk
- Blood pressure screening
- Cholesterol screening for adults of certain ages or at higher risk
- Clinicians offer or refer adults with a Body Mass Index (BMI) of 30 or higher to intensive, multicomponent behavioral interventions
- Colorectal cancer screening for adults over age 45, and a follow-up colonoscopy if the results of the initial test or procedure is abnormal
- Depression screening
- Diabetes (Type 2) screening for adults 40 to 70 years who are overweight or obese
- Diet counseling for adults at higher risk for chronic disease
- Falls prevention (with exercise or physical therapy and vitamin D use) for adults 65 years and over, living in a community setting
- Physical activity counseling for adults who are overweight or obese and have additional cardiovascular disease risk factors for cardiovascular disease
- HIV screening for everyone ages 15-65, and other ages at higher risk
- HIV preexposure prophylaxis (PrEP) with effective antiretroviral therapy for persons at high risk of HIV acquisition
- The following immunization vaccines for adults (doses, recommended ages, and recommended populations vary):

  Hepatitis A
  Hepatitis B
  Herpes Zoster (Shingles)
  Human papillomavirus
  Influenza (Flu shot or Flu mist)
  RSV
  MPOX
  Measles, Mumps, Rubella
  Meningococcal
  Pneumococcal
  Tetanus, Diphtheria, Pertussis
  Varicella
  Haemophilus Influenza type B (Hib)

- Unhealthy alcohol use screening and counseling
- Obesity screening and counseling
- Sexually transmitted infections (STI) counseling
- Tobacco use screening and cessation interventions for tobacco users
- Syphilis screening for adults at higher risk
- Exercise interventions to prevent falls in adults aged 65 years and older who are at increased risk for falls
- Hepatitis C virus (HCV) screening for adults at increased risk, and one time for everyone born 1945-1965
- Hepatitis B virus screening for persons at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence

- Counseling children, adolescents and young adults who have fair skin, about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
- Lung cancer screening in adults 55 and older at high risk for lung cancer because they're heavy smokers or have or have quit within the past 15 years
- Screening for high blood pressure in adults aged 18 years or older
- Screening for abnormal blood glucose and type II diabetes mellitus as part of cardiovascular risk assessment in adults who are overweight or obese
- Low to moderate-dose statin for the prevention of cardiovascular disease (CVD) for adults aged 40 to 75 years with:
    - No history of CVD
    - 1 or more risk factors for CVD (including but not limited to dyslipidemia, diabetes, hypertension, or smoking)
    - A calculated 10-year CVD risk of 10% or greater
- Tuberculin testing for certain adults without symptoms at a high risk of tuberculosis

Preventive Care Services for Women (including pregnant women, and others as specified)

- Bacteriuria urinary tract screening or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast cancer chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive lactation support and counseling from trained **providers**, as well as access to breastfeeding supplies for pregnant and nursing women. Electric breast pumps are limited to 1 per **benefit period**.
- Cervical cancer screening
- Chlamydia infection screening for younger women and women at higher risk
- Certain FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling
- Domestic and interpersonal violence screening and counseling for all women
- Daily supplements of .4 to .8 mg of folic acid for women who may become pregnant
- Diabetes mellitus screening after pregnancy
- Anemia screening on a routine basis
- Urinary tract or other infection screening
- Gestational diabetes screening for women after 24 weeks gestation and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women
- Hepatitis B screening for pregnant women at their first prenatal visit
- HIV screening and counseling
- High risk HPV DNA testing every 3 years for women with normal cytology results who are age 30 or older
- Osteoporosis screening for women over age 65, and younger women with risk factors
- Perinatal depression screening and counseling
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users

- Screening for anxiety in adolescent and adult women, including those who are pregnant, postpartum, or who have not recently been screened
- Sexually transmitted infections (STI) counseling
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services
- Urinary incontinence screening
- Breast cancer mammography screenings including breast tomosynthesis, and if **medically necessary**, a screening MRI
- Intrauterine device (IUD) services related to follow-up and management of side effects, counseling for continued adherence, and device removal
- Aspirin use for pregnant women to prevent preeclampsia
- Screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy

Preventive Care Services for Children (and others as specified)

- Alcohol and drug use assessment for adolescents
- Behavioral assessments for children of all ages
- Blood pressure screenings for children of all ages
- Cervical dysplasia screening for females
- Congenital hypothyroidism screening for newborns
- Critical congenital heart defect screening for newborns
- Depression screening for adolescents
- Development screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children ages 9-11 and 17-21
- Bilirubin screening in newborns
- Fluoride chemoprevention supplements for children without fluoride in their water source
- Fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns, children, and adolescents
- Height, weight, and body mass index measurements
- Hematocrit or hemoglobin screening
- Hemoglobinopathies or sickle cell screening for all newborns
- HIV screening for adolescents at higher risk
- The following immunization vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary):

  Hepatitis A
  Hepatitis B
  Herpes Zoster (Shingles)
  Human papillomavirus
  Influenza (Flu shot or Flu Mist)
  RSV
  Measles, Mumps, Rubella
  Meningococcal
  Pneumococcal
  Tetanus, Diphtheria, Pertussis
  Varicella

- Lead screening for children at risk for exposure
- Autism screening for children at 18 and 24 months of age
- Medical history for all children throughout development
- Obesity screening and counseling

- Oral health risk assessment for younger children up to six years old
- Phenylketonuria (PKU) screening for newborns
- Sexually transmitted infections (STI) prevention and counseling for adolescents
- Tuberculin testing for children at higher risk of tuberculosis
- Vision screening for children and adolescents
- Tobacco use interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents
- Newborn blood screening
- Any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this **benefit** provision.

The FDA approved contraceptive drugs and devices currently covered under this **benefit** provision are listed on the Contraceptive Coverage List. This list is available on the website at www.bcbstx.com and by contacting Customer Service at the toll-free telephone number on the back of your identification card.

Benefits are not available under this **benefit** provision for contraceptive drugs and devices not listed on the Contraceptive Coverage List. You may, however, have coverage under other sections of this **policy**, subject to any applicable **deductible**, **copayments**, **coinsurance**, and/or **benefit** maximum. The Contraceptive Coverage List and the preventive care services covered under this **benefit** provision are subject to change as FDA guidelines, medical management, and medical policies are modified.

Pediatric care, women's preventive care (such as contraceptives) and/or **outpatient** periodic health examinations **covered services** not included above will be subject to the **deductible**, **copayments**, **coinsurance**, and/or **benefit** maximums previously described in this **policy**, if applicable.

Preventive care services received from a non-participating **provider**, non-participating **pharmacy**, or other routine **covered services** may be subject to the **deductible**, **copayments**, **coinsurance**, and/or **benefit** maximum.

Benefits for vaccinations that are considered preventive care services will not be subject to any **deductible**, **copayments**, **coinsurance**, or dollar maximum when such services are received from a participating **provider** or participating **pharmacy** that is contracted for such service.

Vaccinations that are received from a non-participating **provider**, non-participating **pharmacy**, or other routine **covered services** may be subject to the **deductible**, **copayments**, **coinsurance**, and/or **benefit** maximums.

OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES

Prior Authorization: Certain **prescription drugs** require a drug's prescribed use to be evaluated against a predetermined set of criteria to determine **medical necessity** before the prescription will be covered. If the approval is not granted, you may appeal the decision.

Prior authorization will not be required more than once annually for covered drugs used to treat an autoimmune disease, hemophilia, or Von Willebrand disease, except for:

- Opioids, benzodiazepines, barbiturates, or carisoprodol
- **Prescription drugs** that have a typical treatment period of less than 12 months
- Drugs that:
    - Have an FDA boxed warning for use
    - Must have specific **provider** assessment
    - Are used in a manner other than the FDA approved use

Copayment Amounts: Copayment amounts for a participating **pharmacy** or non-participating **pharmacy** are shown on your SCHEDULE OF BENEFITS. The amount you pay depends on the covered drug dispensed. If the **allowable amount** of the covered drug is less than the **copayment**, you will pay the lower cost. When that lower cost is more than the amount you would pay if you purchased the drug without using your BCBSTX **pharmacy benefits** or any other source of drug **benefits** or discounts, you pay such purchase price.

Step Therapy: When you buy a **prescription drug** which has a more cost-effective option in the same therapeutic class and recommended by the pharmacist, coverage will be limited to the cost of the more cost-effective drug.

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

For covered drugs approved by the FDA for treatment of **serious mental illness** in **covered persons** aged 18 years or older, the **covered person** will not be required to:

- Fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug
- Prove a history of failure of more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed

Step Therapy may be required for a trial of a generic or pharmaceutical equivalent of a prescribed **prescription drug** as a condition of continued coverage of the prescribed drug only:

- Once in a **benefit period**
- If the generic or equivalent drug is added to the **plan's drug list**

Split Fill Program: If this is your first time using select medications (e.g., oral cancer medications) or you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14 - 15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. Your **copayments** and/or **coinsurance** may be adjusted to align with the number of pills dispensed. If the medication is working for you and your **physician** wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply.

In addition to the definitions of this **policy**, the following definitions are applicable to this provision:

- **Stage-Four Advanced Metastatic Cancer** means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.
- **Associated conditions** means the symptoms or side effects associated with Stage-Four Advanced Metastatic Cancer or its treatment and which, in the judgment of the **health care practitioner**, further jeopardize the health of a patient if left untreated.

Step Therapy Exception Requests: Your prescribing **physician** or other **health care practitioner** may submit a written request for an exception to the Step Therapy requirements. The Step Therapy Exception Request will be considered approved if we do not deny the request within 72 hours after receipt of the request. If your prescribing **physician** or other **health care practitioner** reasonably believes that denial of the Step Therapy Exception Request could cause you serious harm or death, submission of the request with urgent noted and documenting these concerns will be considered approved if we do not deny the request within 24 hours after receipt of the request. If your Step Therapy Exception Request is denied, you have the right to request an expedited internal appeal and also have the right to request review by an Independent Review Organization as explained in the CLAIM PROVISIONS section of this **policy**.

Prescription Refills: You may obtain **prescription drug** refills from any participating **pharmacy**. Once every 12 months, you will be able to synchronize the start time of certain covered drugs used for treatment and management of a chronic illness, so they are refilled on the same schedule for a given time period. When necessary to fill a partial **prescription order** to permit synchronization, Blue Cross and Blue Shield of Texas will prorate the **copayment** due for covered drugs based on the proportion of days the reduced **prescription order** covers to the regular day supply outlined in the SCHEDULE OF BENEFITS for **outpatient prescription drugs**.

Prescription contraceptives: Covered prescription contraceptives may be obtained as follows:

- An initial three-month supply at one time
- Up to a 12-month supply at one time for subsequent refills
- Maximum of 12-month supply during each 12-month period

Prescription eye drops: Covered prescription eye drops to treat a chronic eye disease or condition will be refilled if:

- The original **prescription order** states that additional quantities of the eye drops are needed
- The refill does not exceed the total quantity of dosage units authorized by the prescribing **health care practitioner** on the original **prescription order**, including refills
- The refill is dispensed on or before the last day of the prescribed dosage period.

The refills are allowed:

- Not earlier than the 21st day after the date a **prescription order** for a 30-day supply is dispensed
- Not earlier than the 42nd day after the date a **prescription order** for a 60-day supply is dispensed
- Not earlier than the 63rd day after the date a **prescription order** for a 90-day supply is dispensed

Dispensing Limits: If a **prescription order** is written for a certain quantity of medication to be taken in a time period directed by a **health care practitioner**, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines. Some drugs covered under your **plan** may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drug supply/fill information, please call the toll free telephone number on the back of your identification card.

Controlled Substance Limitation: If Blue Cross and Blue Shield determines that you be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any additional drugs may be subject to a review for **medical necessity**, appropriateness, and other coverage restrictions such as limiting coverage to services provided by a certain **provider** and/or **pharmacy** for the prescribing and dispensing of the controlled substance and/or limiting coverage to certain quantities.

Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit **benefits** to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your **benefit**, the drug purchased will not be covered under any **benefit** level.

Out-of-Network Pharmacies: When you obtain **prescription drugs**, including diabetic supplies, from an out-of-network **pharmacy** (other than a **network pharmacy**), **benefits** will be provided at 60% of the amount you would have received had you obtained drugs from a **network pharmacy** minus the **copayment** or **coinsurance** amount. You will be responsible for the difference between the **allowable amount** and the billed charges when receiving **prescription drugs** from and out-of-network **pharmacy**.

Specialty Drugs: Coverage for **specialty drugs** is limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your **policy benefits**. Coverage for **specialty drugs** are limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your **policy benefits**. Cost-share will be based on the day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

MedsYourWay™ (“MedsYourWay”) may lower your out-of-pocket costs for select covered drugs purchased at select **network pharmacies**. MedsYourWay is a program that automatically compares available drug discount card prices and prices under your **benefit plan** for select covered drugs and establishes your out-of-pocket cost to the lower price available. At the time you submit or pick up your prescription, present your BCBSTX identification card to the pharmacist. This will identify you as a participant in MedsYourWay and allow you the lower price available for select covered drugs.

The amount you pay for your prescription will be applied, if applicable, to your **deductible** and **out-of-pocket maximum**. Available select covered drugs and drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply, and certain covered drugs or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select covered drugs depending upon which retail **pharmacy** is utilized. For additional information regarding MedsYourWay, please contact Customer Service at the toll-free telephone number on the back of your identification card. Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting Customer Service at the toll-free telephone number on the back of your identification card. In the event MedsYourWay fails to provide or continue to provide the program as stated, there will be no impact to you. In such an event, you will pay the **plan's pharmacy benefit copayment**.

Drug List

A **preferred brand name drug** is subject to the **preferred brand name drug copayment** amount plus any pricing differences that may apply to the covered drug you receive. These drugs are identified on the Performance **Drug List** that is maintained by BCBSTX. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other **pharmacy** and medical related organizations describing clinical outcomes, drug efficacy, and side effect profiles.

BCBSTX will routinely review the **drug list** and periodically adjust it to modify the drug status of existing or new drugs. Changes to this list will be implemented on your anniversary date. The **drug list** and any modifications will be made available to you. We will provide you notification of any change to coverage under the **plan** sixty (60) days before the modification is effective. You may access the website at www.bcbstx.com or call Customer Service at the toll-free telephone number on the back of your identification card to determine if a particular drug is on the Performance **Drug List**.

Note: Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational** and my not be covered.

Drug List Exception Requests

You, your **physician**, or **health care practitioner** with prescriptive authority can ask for a **drug list** exception if your drug is not on the **drug list** (also known as a formulary). To request this exemption, you, your prescribing **physician**, or other **health care practitioner** can call the number on the back of your identification card to ask for a review. You may be required to submit a supporting statement from your prescribing **physician** or other **health care practitioner**.

If you have a health condition that may jeopardize your life, health, your ability to regain maximum function or you are undergoing a current course of treatment using a drug that is not on the **drug list**, an expedited review may be requested. You, your prescribing **physician**, or other **health care practitioner** will be notified of the coverage decision within 24 hours after the request for expedited review is received. If your request is granted, coverage will be provided for the duration of the exigency.

For requests that do not meet the criteria for expedited review, a standard review will be completed and you, prescribing **physician**, or other **health care practitioner** will be notified of the coverage decision within 72 hours after the request for standard review is received. If your request is granted, coverage will be provided for the duration of the prescription, including refills.

If your expedited or standard **drug list** exception request is denied, the decision notice will include information explaining your right to request review by an Independent Review Organization (IRO). You, your prescribing **physician**, or other **health care practitioner** will be notified of the IRO's decision within 24 hours for an expedited review and within 72 hours for a standard review. If your expedited exception request is granted, coverage will be provided for the duration of the exigency. If your standard exception request is granted, coverage will be provided for the duration of the prescription, including refills.

Injectable Drugs

Benefits are available for **medically necessary** injectable drugs which are self-administered that require a written **prescription** by federal law. **Benefits** will not be provided for any self-administered drugs dispensed by a **physician**.

Diabetic Supplies for Treatment of Diabetes

Benefits are available for **medically necessary** items of diabetic supplies for which a **health care practitioner** has written an order. Such diabetes supplies shall include, but are not limited to, the following:

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

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

Insulin Drug Program

The total amount you may pay for a covered drug that contains insulin and is used to treat diabetes will not exceed $25, for up to a 30-day supply, regardless of the amount or type of insulin needed to fill the **prescription order**. The preferred insulin drugs are identified on the **drug list** and do not include an insulin drug administered intravenously.

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

Emergency Refills of Insulin or Insulin-Related Equipment and Supplies

A pharmacist may exercise their professional judgement in refilling a **prescription order** for insulin or insulin related equipment or supplies without the authorization of the prescribing **provider** in the following situations:

- The pharmacist is unable to contact your **provider** after reasonable effort

- The pharmacist has documentation showing the patient was previously prescribed insulin or insulin related equipment or supplies by a **provider**
- The pharmacist assesses the patient to determine whether the emergency refill is appropriate

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

You are responsible for the same **deductible**, **copayments**, and **coinsurance** as for non-emergency refills of diabetes equipment or supplies.

Vaccinations obtained through Network Pharmacies

Benefits for vaccinations are available through certain **network pharmacies** that have contracted with Blue Cross and Blue Shield to provide this service. To locate one of these contracting **network pharmacies** in your area and to find out which vaccinations are covered, you can access the website at www.bcbstx.com or call Customer Service at the toll-free telephone number on the back of your identification card.

Each **network pharmacy** that has contracted with Blue Cross and Blue Shield 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 the **outpatient prescription drug** program. You can refer to your Blue Cross and Blue Shield medical coverage for **benefits** available for childhood immunizations.

Benefits for vaccinations that are considered preventive care services will not be subject to any **deductible**, **copayments**, **coinsurance**, or dollar maximum when such services are received from a **network provider** or **network pharmacy** that is contracted for such service.

Vaccinations that are received from an **out-of-network provider** or from a non-**plan provider** facility or out-of-network **pharmacy**, or other routine **covered services** not provided for under this provision may be subject to the **deductible**, **copayments**, **coinsurance**, and/or **benefit** maximums.

Acne medication

Benefits are available to you for the treatment of acne.

PEDIATRIC VISION CARE

(only for Children under the age of 19)

This PEDIATRIC VISION CARE section is made part of and is in addition to any information you may have in this **policy**. This PEDIATRIC VISION CARE section provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your medical/surgical **benefits** of this **policy**. (Services that are covered under your medical/surgical **benefits** of this **policy** are not covered under this PEDIATRIC VISION CARE **section**.) All provisions in this **policy** apply to this PEDIATRIC VISION CARE section unless specifically indicated otherwise below.

This BCBSTX vision care **plan** allows you to select the provider of your choice, either an EyeMed contracting **provider**, or a non-contracting **provider**. BCBSTX has designed **benefit plans** to deliver quality care, matched with comprehensive **benefits**, at the most affordable cost, through EyeMed contracting **providers**. You will have a higher **benefit** level if you choose to receive pediatric vision care services from an EyeMed contracting **provider**.

Definitions

Benefit Period - For purposes of this PEDIATRIC VISION CARE section, a period of time that begins on the later of:

- Your effective date of coverage under this PEDIATRIC VISION CARE section
- The last date a vision examination was performed on you or that **vision materials** were provided to you, whichever is applicable. (A **benefit period** does not coincide with a calendar year and may differ for each **covered person** of a group or family.)

Eye Care Expenses - For purposes of this PEDIATRIC VISION CARE section, expenses related to vision or medical eye care services, procedures, or products.

Provider - For purposes of this PEDIATRIC VISION CARE section, a licensed ophthalmologist, optometrist, or therapeutic optometrist operating within the scope of their license, or a dispensing optician.

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

Eligibility

Children who are covered under this **policy's** medical/surgical **benefits**, up to age 19, are eligible for coverage under this PEDIATRIC VISION CARE section. NOTE: Once coverage is lost under the medical/surgical **benefits** of this **policy**, all **benefits** cease under this PEDIATRIC VISION CARE section. Extension of **benefits** due to disability, state or federal continuation coverage, and conversion option privileges are not available under this PEDIATRIC VISION CARE section.

Limitations and Exclusions

In addition to the general limitations and exclusions listed in this **policy**, this PEDIATRIC VISION CARE section does not cover services or materials connected with or charges arising from:

- Any vision service, treatment or materials not specifically listed as a **covered service**
- Services and materials not meeting accepted standards of optometric practice
- Services and materials resulting from your failure to comply with professionally prescribed treatment

- Services rendered after the date you cease to be covered under this **policy**, except when **vision materials** ordered before coverage ended are delivered, and the services rendered to you are within 31 days from the date of such order
- Telephone consultations
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances
- Office infection control charges
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts
- State or territorial taxes on vision services performed
- Medical treatment of eye disease or **injury**
- Visual therapy
- Special lens designs or coatings other than those described in this section
- Replacement of lost/stolen eyewear
- Non-prescription (Plano) lenses
- Non-prescription sunglasses
- Two pairs of eyeglasses in lieu of bifocals
- Services not performed by licensed personnel
- Prosthetic devices and services
- Insurance of contact lenses
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother, or sister, by blood, marriage, or adoption
- Services covered under the medical/surgical **benefits** of this **policy**
- Replacement of lost, stolen, damaged, or broken materials, until the next **benefit** frequency when **vision materials** would next become available
- Services of unlicensed personnel
- Orthoptic or vision training
- Aniseikonic spectacle lenses
- Any eye or vision examination, or any corrective eyewear required as a condition of employment or safety eyewear
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency program whether federal, state, or subdivisions thereof

How the Vision Care Plan Works

Under the vision care **plan** option, you may visit any **provider** and receive **benefits** for a vision examination. In order to maximize **benefits** for most covered **vision materials**, however, you must purchase them from an EyeMed contracting **provider**.

Before you go to an EyeMed contracting vision care **plan provider** for an eye examination, eyeglasses, or contact lenses, you should call ahead for an appointment. When you arrive, you should show the receptionist your identification card. If you forget to take your card, you should say that you are a member of the BCBSTX vision care **plan** so that your eligibility can be verified.

To locate an EyeMed contracting vision care **provider**, you can visit the website at www.bcbstx.com or contact Customer Service at the toll-free telephone number on the back of your identification card to obtain a list of the EyeMed contracting vision care **plan providers** nearest you.

If you obtain glasses or contacts from a non-contracting **provider**, you must pay the **provider** in full and submit a **claim** for reimbursement. You should see the CLAIM PROVISIONS section of this **policy** for more information.

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

Fees charged for services other than a **covered vision** examination or covered **vision materials** and amounts in excess of those payable under this PEDIATRIC VISION CARE section must be paid in full by you to the **provider**, whether or not the **provider** participates in the vision care **plan** network. **Benefits** under this PEDIATRIC VISION CARE section may not be combined with any discount, promotional offering, or other group **benefit** plans. Allowances are one-time use **benefits**; no remaining balances are carried over to be used later.

Coordination of Benefits for Pediatric Vision Care

If you are covered by at least two different health care plans that provide **benefits** for **eye care expenses** and each plan provides coverage for the same vision or medical eye care services, procedures or products:

- The issuer of the primary health care plan or vision **benefit** plan, as described in the COORDINATION OF BENEFITS section of this **policy**, is responsible for **eye care expenses** covered under the plan up to the full amount of any plan coverage limit applicable to the covered **eye care expenses**.
- Before the plan coverage limit described above is reached, the issuer of a secondary health care plan or vision **benefit** plan is responsible only for **eye care expenses** covered under the plan that are not covered under the health care plan or vision **benefit** plan issued by the primary plan issuer.
- After the plan coverage limit described above has been reached, the secondary plan issuer, in addition to the responsibilities for services not covered by the primary plan but covered by the secondary plan, is responsible for any **eye care expenses** covered by both plans that exceed the plan coverage limit of the primary plan, up to the coverage limit of the secondary plan.
- When you are covered by more than one health care plan or vision **benefit** plan that provides **benefits** for **eye care expenses**, you may use each plan on the same date of service up to the coverage limit of each plan.
- A vision **benefit** plan issuer shall coordinate **benefits** with a health care plan issuer if both provide **benefits** for **eye care expenses**.
- A vision **benefit** plan issuer may not require a **claim** denial before adjudicating a **claim** up to the coverage limit of the **plan**.
- Nothing in this section prevents a secondary plan issuer from requiring proof that a related **claim** has been submitted to a primary plan issuer for purposes of determining the remaining balance up to the secondary plan's coverage limits.
- If a secondary plan issuer requires proof that a related **claim** has been submitted to a primary plan issuer, the mechanism of providing proof must be through an online submission.

SCHEDULE OF BENEFITS - PEDIATRIC VISION CARE

Vision Care Services	EyeMed Provider Benefit	Non-Contracting Provider Reimbursement Amount
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
Any available frame at provider location	No Copayment on provider-designated frame; $150 allowance on non-provider designated frame, 20% off balance over $150	Up to $75
Standard Plastic Lenses:		
Single Vision	No Copayment	Up to $25
Bifocal	No Copayment	Up to $40
Trifocal	No Copayment	Up to $55
Lenticular	No Copayment	Up to $55
Lens Options:		
UV Treatment	No Copayment	N/A
Tint (Fashion & Gradient & Glass-Grey)	No Copayment	Up to $12
Standard Plastic Scratch Coating	No Copayment	Up to $12
Standard Polycarbonate	No Copayment	Up to $32
Glass	No Copayment	N/A
Oversized	No Copayment	N/A
Photochromic / Transitions Plastic	$75	N/A
Contact Lenses: *(Contact Lens allowance includes materials only)*		
Conventional	No Copayment; $150 allowance, plus 15 % off balance over $150	Up to $150
Disposable	No Copayment; $150 allowance, plus balance over $150	Up to $150
Medically Necessary *Note: In some instances, **participating providers** may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, a **covered person** may submit a **claim** for the remaining balance (the combined reimbursement will not exceed the total allowance).*	No Copayment, Paid-in-Full	Up to $210

Frequency:	
Examinations, Lenses, or Contact Lenses	Once every Benefit Period
Frame	Once every Benefit Period
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.	
Value-added features: Laser vision correction: 15% off Retail Price or 5% off promotional price.	
Additional Pairs Benefit: Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded Benefit has been used.	
Additional Benefits:	
Medically Necessary contact lenses: Contact lenses may be determined to be **medically necessary** and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be **medically necessary** and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be **medically necessary** in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, and irregular astigmatism. **Medically necessary** contact lenses are dispensed in lieu of other eyewear. **Participating providers** will obtain the necessary **prior authorization** for these services.	
Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for **covered persons** with low vision. Covered low vision services (both contracting and non-contracting **providers**) will include one comprehensive low vision evaluation every 5 years; items such as high-power spectacles, magnifiers, and telescopes; and follow-up care – four visits in any five-year period. **Participating providers** will obtain the necessary **prior authorization** for these services.	
Warranty: Warranty limitations may apply to **provider** or retailer supplied frames and/or eyeglass lenses. **Covered persons** should ask their **provider** for details of the warranty that is available to them.	
Note: Additional discounts on materials may be available.	

*The "covered charge" is the rate negotiated with **network providers** for a particular covered service.

The **plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

EXCLUSIONS AND LIMITATIONS

Except as specified in this **policy**, coverage is not provided for loss or charges incurred by or resulting from:

- Charges that are not **medically necessary** or in excess of the **allowable amount**
- Services that are provided, normally without charge, by the Student Health Center, infirmary, or **hospital**, or by any person employed by the **institution**
- This **plan** does not cover cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.
- Acupuncture procedures
- Breast augmentation
- Routine circumcision, unless the procedure is **medically necessary** for treatment of a **sickness**, disease or functional congenital disorder not excluded hereunder or as may be necessitated due to an **accident** or except for covered infants within 31 days of birth
- Any charges for **surgery**, procedures, treatment, facilities, supplies, devices, or drugs that the **plan** determines are **experimental/investigational** or unproven. You may contact Customer Service at the toll-free telephone number on the back of your identification card for more information about what **experimental/investigational** services or supplies may be excluded.
- Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT® Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines
- Management and treatment of Idiopathic Environmental Intolerance (IEI), including laboratory or other diagnostic tests to affirm the diagnosis of IEI
- Abortions are limited to pregnancies that, as certified by a **physician**, place the woman in danger of death
- Expenses incurred for **injury** or **sickness** arising out of or in the course of your employment, regardless of if **benefits** are, or could be paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation
- Treatment, services or supplies in a Veteran's Administration or **hospital** owned or operated by a national government or its agencies unless there is a legal obligation for you to pay for the treatment
- Expenses in connection with services and prescriptions for eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser **surgery** for vision correction or the treatment of visual defects or problems, except for pediatric vision
- Reconstructive **surgery**, plastic **surgery**, cosmetic **surgery**, or complications resulting therefrom, including **surgery** to improve or restore a **covered person's** appearance, unless:
    - Needed to repair conditions resulting from an accidental **injury**
    - For the improvement of the physiological functioning of a malformed body member resulting from a congenital defect
    - For the treatment provided for reconstructive **surgery** following cancer **surgery**

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a **covered service** unless such care and services are performed solely and directly as a result of a mastectomy which is **medically necessary**.
- Riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a

fare-paying passenger in an aircraft operated by a commercial scheduled airline

- **Injury** resulting from sky diving, parachuting, hang gliding, glider flying, parasailing, sailplaning, bungee jumping
- War, or any act of war, whether declared or undeclared or while in service in the active or reserve Armed Forces
- Any expenses incurred in connection with sexual dysfunctions, sterilization reversal, or vasectomy reversal
- In-vitro fertilization
- 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
- Donor expenses for a **covered person** in connection with an organ and tissue transplant if the recipient is not covered under this **policy**
- Expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to **covered oral surgery** or the repair of **injuries** to sound natural teeth caused by a covered **injury**
- Hirsutism
- Weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind
- **Surgery** for the removal of excess skin or fat
- Nutrition programs, except as related to treatment for diabetes
- Custodial Care
- Long term care service
- Bariatric **surgery**
- Private duty nursing services
- Weight loss programs
- Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy

Prescription Drug coverage is not provided for:

- Refills in excess of the number specified or dispensed after one (1) year from the date of the prescription
- Drugs labeled “Caution - limited by federal law to investigational use” or experimental drugs
- Drugs determined to have inferior efficacy or significate safety issues
- Immunizing agents, biological sera, blood, or blood products administered on an **outpatient** basis, except as specifically provided in this **policy**
- Any devices, appliances, support garments, hypodermic needles except as used in the administration of insulin, or non-medical substances regardless of their intended use
- Drugs used for cosmetic purposes, including but not limited to Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control, etc.
- Fertility agents or sexual enhancement drugs, medications, or supplies for the treatment of impotence and/or sexual dysfunction, including but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra
- Lost or stolen prescriptions
- Drugs prescribed and dispensed for the treatment of weight management only, unless

prescribed for another **medically necessary** health condition

- Any drugs provided for reduction of obesity or weight, even if the covered person has other health conditions which might be helped by a reduction of obesity or weight
- Non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a **prescription order**. (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)
- Brand name proton pump inhibitors
- 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
- Drugs which are not included on the **drug list** unless specifically covered elsewhere in this **policy** and/or such coverage is required in accordance with applicable law or regulatory guidance
- Select medications may be excluded from the medical **benefit** when a self-administered formulation of the product is available.

Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit **benefits** to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your **benefit**, the drug purchased will not be covered under any **benefit** level.

Some laboratory services are not covered by your **plan**. The following laboratory services are not covered:

- Vitamin B12 testing or screening for a Vitamin B12 deficiency in healthy, asymptomatic individual; homocysteine or holotranscobalamin testing to screen for or confirm a Vitamin B 12 deficiency; or Vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency
- Vitamin D testing - Routine screening for vitamin D deficiency with serum testing in asymptomatic individuals and/or during general encounters
- Hemoglobin A1c testing in the following situations:
    - If you have had a blood transfusion within the past 120 days
    - If you have a condition associated with increased red blood cell turnover
    - If you are also being measured for fructosamine
- Influenza Testing - Viral culture testing for influenza in an **outpatient** setting; **outpatient** influenza testing in asymptomatic patients; serology testing for influenza under any circumstance
- Cardiac **Biomarkers** - Measurement of cardiac **biomarkers** for the diagnosis a heart attack if you have symptoms of acute coronary syndrome such as chest pain; or measurement of cardiac **biomarkers** if you have symptoms of acute coronary syndrome and received services in a setting that cannot perform an evaluation for a heart attack, such as an independent lab or **physician's** office
- Drug testing in an **outpatient** setting is not covered in the following situations:
    - Testing to confirm the presence and/or amount of drugs in your system is not covered when laboratory-based definitive drug testing is requested without any prior screening test results, or when laboratory-based definitive drug testing is requested for larger than seven drug classes panels

- Use of proprietary drug tests such as RiskviewRX Plus
- Specific validity testing, including, but not limited to the following tests: urine specific gravity, urine creatinine, pH, urine oxidant level, and genetic identity testing, are included in the panel test and therefore will not be covered if submitted individually if a urine panel test was also ordered at the same time
- Testing for any American Medical Association definitive drug class codes
- Same-day testing for the same drug or metabolites from two different samples (e.g., both a blood and a urine specimen)
- Testing of samples with abnormal validity tests
- Drug testing for patients in a facility setting (**inpatient** or **outpatient**) are not separately covered, as they are included in the daily charge at the facility
- Your plan does not cover both qualitative (type of drug) testing and presumptive (to verify presence of drugs) testing on the same specimen

- Folate testing - Measurement of RBC folate is not covered. Measurement of serum folate concentration is only covered when you have been diagnosed with megaloblastic or macrocytic anemia and those conditions do not resolve after folic acid treatment
- Pancreatic Enzyme Testing is not covered the following situations:
  - More than once per visit
  - As part of ongoing assessment or therapy of chronic pancreatitis
  - During a general exam without abnormal findings if you do not have symptoms and are not pregnant
  - For measurement of the following **biomarkers** for the diagnosis or assessment of acute pancreatitis, prognosis, and/or determination of severity of acute pancreatitis is not covered: measurement of both amylase AND serum lipase, serum trypsin/trypsinogen/TAP (trypsinogen activation peptide), C-Reactive Protein (CRP), Interleukin-6 (IL-6), Interleukin-8 (IL-8), or Procalcitonin
- Cardiovascular disease risk assessment testing is not covered in the following situations:
  - High-sensitivity C-Reactive Protein is not covered except when a risk based treatment decision is not certain after having a quantitative risk assessment using American College of Cardiology/ American Heart Association (ACC/AHA) calculator to calculate 10-year risk of Cardiovascular disease CVD
  - Testing for High-sensitivity C-Reactive Protein is not covered as a screening test for the general population or for monitoring response to therapy
  - Measurement of High-sensitivity cardiac troponin T is not covered for cardiovascular risk assessment and stratification in the **outpatient** setting
  - Homocysteine testing for cardiovascular disease risk assessment screening, evaluation and management is not covered
  - Novel Cardiovascular Biomarkers such as measurement of novel lipid and non-lipid **biomarkers** is not covered as an add on to LDL cholesterol in the risk assessment of cardiovascular disease
  - Cardiovascular risk panels, consisting of multiple individual **biomarkers** intended to assess cardiac risk (other than simple lipid panels), are not covered
  - Serum Intermediate Density Lipoprotein is not covered as an indicator of cardiovascular disease risk
  - Measurement of lipoprotein-associated phospholipase is not covered as an indicator of risk of cardiovascular disease
  - Measurement of secretory type II phospholipase is not covered in the assessment of cardiovascular risk for all indications

    - Measurement of long-chain omega-3 fatty acids in red blood cell membranes, including but not limited to its use as a cardiac risk factor is not covered
    - All other tests for assessing CHD risk are not covered
- Allergen Testing is not covered in the following situations:
    - Routine re-testing for confirmed allergies to the same allergens is not covered except in children and adolescents with positive food allergen results to monitor for allergy resolution
    - The Antigen Leukocyte Antibody test (ALCAT) is not covered
    - In-vitro testing of allergen specific IgG or non-specific IgG, IgA, IgM, and/or IgD in the evaluation of suspected allergy is not covered
    - Basophil Activation flow cytometry testing for measuring hypersensitivity to allergens is not covered
    - In-vitro allergen testing using bead-based epitope assays is not covered
    - In-vitro testing of allergen non-specific IgE is not covered
- Testosterone testing - The following tests are not covered:
    - Testing for serum free testosterone and/or bioavailable testosterone as primary testing (i.e., in the absence of prior serum TOTAL testosterone testing)
    - Testing for serum total testosterone, free testosterone, and/or bioavailable testosterone in asymptomatic individuals or in individuals with non-specific symptoms
    - Testing for serum testosterone for the identification of androgen deficiency
    - Salivary testing for testosterone
    - Measurement of serum dihydrotestosterone in individuals except in diagnosing 5-alpha reductase deficiency in individuals with ambiguous genitalia, hypospadias, or microphallus
- Thyroid Disease Testing is not covered in the following situations:
    - Testing for thyrotropin-releasing hormone (TRH) or thyroxine-binding globulin (TBG) for the evaluation of the cause of hyperthyroidism or hypothyroidism is not covered
    - Testing for thyroid dysfunction during a general exam without abnormal findings for asymptomatic nonpregnant individuals is not covered
- Onychomycosis Testing is not covered in the following situations:
    - Nucleic acid testing, attenuated total-reflectance fourier transform infrared (ATR-FTIR) spectroscopy and testing for the presence of fungal-derived sterols (e.g., ergosterol) to screen for, diagnose, or confirm onychomycosis is not covered
- Three-dimensional (3D), four-dimensional (4D), and five-dimensional (5D) obstetrical ultrasounds

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

BCBSTX has the right to coordinate benefits between this **health care plan** and any other **health care plan** covering you.

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

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

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

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

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

a. For a **dependent** child, whose parents are married or are living together, whether or not they have ever been married:
   i. The **health care plan** of the parent whose birthday falls earlier in the calendar year is the primary plan
   ii. If both parents have the same birthday, the **health care plan** that has covered the parent the longest is the primary plan.

b. For a **dependent** child, whose parents are divorced, separated, or not living together, whether or not they have ever been married:
   i. If a court order states that one of the parents is responsible for the **dependent** child's health care expenses or health care coverage and the **health care plan** of that parent has actual knowledge of those terms, that **health care plan** is primary. This rule applies to plan years commencing after the **health care plan** is given notice of the court decree.
   ii. If a court order states that both parents are responsible for the **dependent** child's health care expenses or health care coverage, the provisions of 2a must determine the order of benefits.
   iii. If a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the

dependent child, the provisions of 2a must determine the order of benefits.

iv. If there is no court order allocating responsibility for the **dependent** child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The **health care plan** covering the custodial parent
    - The **health care plan** covering the spouse of the custodial parent
    - The **health care plan** covering the noncustodial parent
    - The **health care plan** covering the spouse of the noncustodial parent

c. For a **dependent** child, covered under more than one **health care plan** of individuals who are not the parents of the child, the provisions of 2a or 2b must determine the order of benefits as if those individuals were the parents of the child.

d. For a **dependent** child, who has coverage under either or both parents' **health care plans** and has their own coverage as a **dependent** under a spouse's **health care plan**, paragraph 5, below applies.

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

3. **Active, Retired, or Laid-Off Employee**. The **health care plan** that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The **health care plan** that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a **dependent** of an active employee and that same person is a **dependent** of a retired or laid-off employee. If the **health care plan** that covers the same person is as a retired or laid-off employee or as a **dependent** of a retired or laid-off employee does not have this rule, and as a result, the **health care plans** do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1, above can determine the order of benefits.

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

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

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

When this **health care plan** is secondary, it may reduce its **benefits** so that the total benefits paid or provided by all **health care plans** are not more than the total **allowable expenses**. In determining the amount to be paid for any **claim**, the secondary plan will calculate the **benefits** it would have paid in the absence of other health care coverage and apply that calculated amount to any **allowable expense** under its **health care plan** that is unpaid by the primary plan. The secondary plan may then reduce its

payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all **health care plans** for the **claim** equal 100 percent of the total **allowable expense** for that **claim**. In addition, the secondary plan must credit to its plan deductible (if applicable) any amounts it would have credited to its deductible in the absence of other health care coverage. If a **covered person** is enrolled in two or more closed panel **health care plans** and if, for any reason, including the provision of service by a nonpanel **provider**, **benefits** are not payable by one closed panel **health care plan**. COB must not apply between that **health care plan** and other closed panel **health care plans**. When **benefits** are available to you as primary benefits under Medicare, those benefits will be determined first, and **benefits** under this **plan** may be reduced accordingly. You must complete and submit consents, releases, assignments, and other documents requested by BCBSTX to obtain or assure reimbursement by Medicare.

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

None of the above rules as to Coordination of Benefits shall delay your health services covered under this **plan**.

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

CLAIM PROVISIONS

Notice of Claim

Written (or authorized electronic or telephonic) notice of a **claim** under this **policy** must be given to us or our administrator within 20 days after any loss covered by this **policy** occurs, or as soon thereafter as is reasonably possible. The notice should identify the **covered person** and the policy number.

Claim Forms

Upon receipt of a written notice of **claim**, we or our administrator will send **claim** forms to you within 15 days. If the forms are not furnished within 15 days, you will satisfy the proof of loss requirements of this **policy** by submitting written proof describing the occurrence, nature, and extent of the loss for which **claim** is made.

Proof of Loss

Written (or authorized electronic or telephonic) proof of loss must be furnished to us or our administrator within 90 days after the date of loss. Failure to furnish proof within the time required will not invalidate nor reduce any **claim** if it is not reasonably possible to give proof within 90 days, provided:

- It was not reasonably possible to provide proof in that time
- The proof is given within one year from the date proof of loss was otherwise required. This one-year limit will not apply in the absence of legal capacity.

Written proof of loss for services or supplies provided by a **network provider** must be furnished to us by the **network provider** in strict compliance with the written contract between us and the **network provider**. In the event such written contract does not contain a time limitation for furnishing proof of loss, the provisions above shall be applicable.

Time for Payment of Claim

Benefits payable under this **policy** will be paid immediately upon receipt of satisfactory written proof of loss.

Payment of Claims

All **benefits** will be payable to the **provider** as soon as we receive due written proof of loss. Within 15 days after receipt of the proof of loss, we will either:

- Pay the **benefits** due
- Mail you a statement of the reasons why the **claim** has, in whole or in part, not been paid

Such a statement will also list any documents or information that we need to process the **claim** or that part of the **claim** not paid. When all of the listed documents or information are received, we will have 15 workdays in which to:

- Process and either pay the **claim**, in whole or in part, or deny it
- Give you the reasons we may have for denying the **claim** or any part of it

If we are unable to accept or reject the **claim** within this 15-workday period, we will notify you of the reason for the delay. We will have 45 additional days to accept or reject the **claim**.

In the event that we do not comply with its obligations under this *Payment of Claims* provision, we will pay the interest at a rate required by law on the proceeds or **benefits** due under the terms of this **policy**.

All **benefits** are payable to you, except that:

1. If you receive medical assistance from the State of Texas, we will pay any **benefits** based on your medical expenses to the Texas Health and Human Services Commission, but not more than the actual cost that the Department pays for those expenses. Only the balance, if any, of such **benefits** will then be payable to you.

2. All **benefits** paid on behalf of a **dependent** child under this **policy** must be paid to the Texas Health and Human Services Commission whenever:
    - The Texas Health and Human Services Commission is paying benefits pursuant to the Human Resource Code; and
    - The parent who is covered by this **policy** has possession or access to the child pursuant to a court order or is not entitled to access or possession of the child and is required by the court to pay child support.

3. If the **insured** is not the custodial parent of the **dependent** child covered by this **policy**, **benefits** may be payable to the non-plan covered parent, provided that the following information is submitted to us:
    - Written notice that the non-plan covered parent is the custodial parent of the **dependent** child
    - A certified copy of a court order designating the non-plan covered parent as the custodial parent (or other evidence designated by rule of the State Board of Insurance); and
    - A fully completed **claim** form. These requirements will not apply if a valid assignment of **benefits** for an unpaid medical bill has been made or if the **insured** has paid a portion of the medical bill and files a **claim**.

4. If the **covered person** is unable to execute a valid release, we can:
    - Pay any **providers** on whose charges the **claim** is based toward the satisfaction of those charges
    - Pay any person or institution that has assumed custody and principal support of the **covered person**

5. If the **covered person** dies while any accrued **benefits** remain unpaid, we can pay any **provider** on whose charges the **claim** is based toward the satisfaction of those charges. Then, any **benefits** that still remain unpaid can be paid to the **covered person's** beneficiary or estate.

We will be discharged to the extent of any such payments made in good faith.

Non-Duplication Of Benefits Limitation

If benefits are payable under more than one (1) **benefit** provision contained in this **policy**, **benefits** will be payable only under the provision providing the greater **benefit**.

Payment to Possessory or Managing Conservator of Dependent Child

For a minor child who otherwise qualifies as a **dependent** of you, **benefits** may be paid on behalf of the child to a person who is not you if an order issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.

To be entitled to receive **benefits**, a possessory or managing conservator of a child must submit to us, with the **claim** form, written notice that such person is the possessory or managing conservator of the child on whose behalf the **claim** is made and submit a certified copy of a court order establishing the person as the possessory or managing conservator. This will not apply in the case of any unpaid medical bills for which a valid assignment of **benefits** has been exercised or to **claims** submitted by you where you had paid any portion of a medical bill that would be covered under terms of this **policy**.

Review Of Claim Determinations

Claim Determinations

When BCBSTX receives a properly submitted **claim**, we have authority and discretion under this **policy** to interpret and determine **benefits** in accordance with the **policy** provisions. BCBSTX will receive and review **claims** for **benefits** and will accurately process **claims** consistent with administrative practices and procedures established in writing. You have the right to seek and obtain a review by BCBSTX of any determination of a **claim**, any determination of a request for **prior authorization**, or any other determination made by BCBSTX of your **benefits** under this **policy**.

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

If a Claim Is Denied or Not Paid in Full

On occasion, BCBSTX 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 BCBSTX then review this **policy** 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 BCBSTX 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 BCBSTX with the following information, if applicable:

- The reasons for determination
- The professional specialty of the **physician** who made the determination
- A reference to the **benefit** provisions on which the determination is based, or the contractual, administrative or protocol for the determination
- A description of additional information which may be necessary to perfect the **claim** and an explanation of why such material is necessary

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

- An explanation of our internal review/appeals processes and how to initiate a review/appeal

- In certain situations, a statement in non-English language(s) that the written notice of the **claim** denial and certain other **benefit** information may be available (upon request) in such non-English language(s).
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX.
- The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the **claim** for **benefits**
- Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request
- An explanation of the scientific or clinical judgment relied on in the determination as applied to **covered person's** medical circumstances. If the denial was based on **medical necessity**, experimental treatment, or similar exclusion, a statement that such explanation will be provided free of charge upon request.
- An explanation of your right, if applicable, to request review by an Independent Review Organization (IRO), at the expense of BCBSTX, including the request form
- In the case of a denial of an urgent care clinical **claim**, a description of the expedited review procedure applicable to such **claims**. An urgent care clinical **claim** decision may be provided orally, so long as a written notice is furnished to the **covered person** within 3 days of oral notification.
- In life-threatening, circumstances, or if BCBSTX has discontinued coverage of **prescription drugs** or intravenous infusions for which you were receiving health **benefits** under the **plan**, you are entitled to an immediate appeal to an IRO and are not required to comply with BCBSTX's appeal of an Adverse Determination process.
- Contact information for applicable office of health insurance consumer assistance or ombudsman

Timing of Required Notices and Extensions

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

1. **Urgent Care Clinical Claim** is any pre-service **claim** for **benefits** for **medical care** or treatment with respect to which the application of regular time periods for making a health claim determination could seriously jeopardize your life or health, or your ability to regain maximum function or, in the opinion of a **physician** with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment.

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

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

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your **claim** involves post-stabilization treatment subsequent to emergency treatment or a life-threatening condition, BCBSTX will issue and transmit a determination indicating whether proposed services have received **prior authorization** within:	The time appropriate to the circumstances relating to the delivery of the services and your condition, but in no case to exceed **one hour**
If your **claim** is incomplete, BCBSTX must notify you of any additional information needed to complete your **claim** within:	**24 hours**
If you are notified that your **claim** is incomplete, you must then provide the additional information to BCBSTX within:	**48 hours** after receiving notice
*BCBSTX must notify you of the **claim** determination (whether adverse or not):*	
If the initial **claim** is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
If the initial **claim** is incomplete, within:	**48 hours** after the earlier of our receipt of the additional information or the end of the period within which the additional information was to be provided

*If the request is received outside the period during which BCBSTX are required to have personnel available to provide determinations, BCBSTX will make the determination within one hour from the beginning of the next time period requiring appropriate personnel to be available. You do not need to submit urgent care clinical **claims** in writing. You should call BCBSTX at the toll-free number listed on the back of your identification card as soon as possible to submit an urgent care clinical **claim**.

Note: If proposed **medical care** or health care service requires **prior authorization** by BCBSTX, we will issue a determination no later than the third calendar day after our receipt of the request. If you are an **inpatient** in a healthcare facility at the time the services are proposed, BCBSTX will issue our determination within 24 hours after our receipt of the request.

Pre-Service Claims

Type of Notice	Timing
*BCBSTX must notify you of the **claim** determination (whether adverse or not):*	
If BCBSTX has received all information necessary to complete the review, within:	**2 working days** of or our receipt of the complete **claim** or **3 calendar days** of the request, whichever is sooner, if the **claim** is approved and **3 calendar days** of the request, if the **claim** is denied.

Note: For **claims** involving services related to acquired brain **injury**, BCBSTX will issue our determination no later than 3 calendar days after we receive the request.

Post-Service Claims (Retrospective Review)

Type of Notice or Extension	Timing
If your **claim** is incomplete, BCBSTX must notify you within:	**30 days**
If you are notified that your **claim** is incomplete, you must then provide completed **claim** information to BCBSTX within:	**45 days** after receiving notice
*BCBSTX must notify you of any adverse **claim** determination:*	
If the initial **claim** is complete, within:	**30 days** after receipt of the **claim**
After receiving the completed **claim** (if the initial **claim** is incomplete), within:	**45 days**, if we extended the period, less any days already utilized by BCBSTX during our review*

This period may be extended one time by BCBSTX for up to 15 days, provided that we both (1) determine that such an extension is necessary due to matters beyond the control of the **plan** and (2) notify you in writing, prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the date by which BCBSTX expect to render a decision. If the period is extended because BCBSTX requires additional information from you or your **provider**, the period for our making the determination is tolled from the date BCBSTX sends notice of extension to you until the earlier of:

- The date on which we receive the information
- The date by which the information was to be submitted

Concurrent Care

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

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An **adverse benefit determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a **benefit** in response to a **claim**, pre-service **claim,** or urgent care **claim**, including any such denial, reduction, termination, or failure to provide or make payment for, a **benefit** resulting from the application of any utilization review, as well as a failure to cover an item or service for which **benefits** are otherwise provided because it is determined to be **experimental/investigational** or not **medically necessary** or appropriate.

A **final internal adverse benefit determination** means an **adverse benefit determination** that has been upheld by BCBSTX at completion of our internal review/appeal process.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care **provider**, the denial of **emergency care** or continued hospitalization, the denial of a step therapy exception request, or the discontinuance by BCBSTX of **prescription drugs** or intravenous infusions for

which you were receiving health **benefits** under this **policy**. Before authorization of **benefits** for an approved ongoing course of treatment/continued hospitalization is terminated or reduced, BCBSTX will provide you with notice at least 24 hours before the previous **benefits** authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, BCBSTX will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal if additional information is needed to review the appeal. BCBSTX shall render a determination on the appeal within one working day from the date all information necessary to complete the appeal is received by us, but no later than 72 hours after the appeal has been received by BCBSTX.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a **claim**, any determination of a request for **prior authorization**, or any other determination made by BCBSTX in accordance with the **benefits** and procedures detailed in your **policy**.

An appeal of an **adverse benefit determination** may be requested orally or in writing by you or a person authorized to act on your behalf. In some circumstances, a health care **provider** may appeal on their own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an authorized representative form, you or your representative may call BCBSTX at the toll-free telephone number on the back of your identification card.

Your appeal will be acknowledged within five business days of the date BCBSTX receives it. The acknowledgment will include additional information concerning the appeal procedures and identify any additional documents that you must submit for review. If your appeal is made orally, BCBSTX will send you a one-page appeal form.

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

- Within 180 days after you receive notice of a denial or partial denial, you may call or write to our Administrative Office. BCBSTX will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

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

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

During the course of your internal appeal(s), BCBSTX will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon, or generated by BCBSTX in connection with the appealed **claim**, as well as any new or additional rationale for a denial at the internal appeals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. BCBSTX may extend the time period described in this **policy** for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial **benefit** determination regarding the **claim** is based in whole or in part on a medical judgment, the appeal determination will be made by a **physician** associated or contracted with BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your **claim**. No deference will be given to the initial **adverse benefit determination**. Before you or your authorized representative may bring any action to recover **benefits**, you must exhaust the appeal process and must raise all issues with respect to a **claim** and must file an appeal or appeals and the appeals must be finally decided by BCBSTX.

If you have any questions about the **claim** procedures or the review procedure, write to our Administrative Office or call Customer Service at the toll-free telephone number on the back of your identification card.

Timing of Appeal Determinations

BCBSTX will render a determination on non-urgent concurrent, pre-service appeals that do not require expedited review or **prior authorization** and post-service appeals as soon as practical, but in no event later than 30 days after the appeal has been received by us.

For **claims** involving services related to acquired brain **injury**, BCBSTX will render an appeal determination within 3 business days after the appeal is received by us.

Notice of Appeal Determination

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

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

- A reason for the determination
- The professional specialty of the **physician** who made the determination
- A reference to the **benefit plan** provisions on which the determination is based, and the contractual, administrative or protocol for the determination
- Subject to privacy laws and other restrictions, if any, the identification of the **claim**, date of service, health care **provider**, **claim** amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
- An explanation of the external review processes (and how to initiate an external review) including a copy of a request for review by IRO form
- In certain situations, a statement in non-English language(s) that the written notice of the **claim** denial and certain other **benefit** information may be available (upon request) in such non-English language(s).
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX.

- The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the **claim** for **benefits**
- Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request.
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request.
- A description of the standard that was used in denying the **claim** and a discussion of the decision
- Your right, if applicable, to request external review by and Independent Review Organization
- Contact information for applicable office of health insurance consumer assistance or ombudsman

If BCBSTX denies your appeal, in whole or in part, or you do not receive a timely decision, you are able to request an external review of your **claim** by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the HOW TO APPEAL A FINAL INTERNAL ADVERSE DETERMINATION TO AN INDEPENDENT REVIEW ORGANIZATION (IRO) section below.

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

An **adverse determination** means a determination by BCBSTX or our designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a **covered service** has been reviewed and, based upon the information provided, is determined to be **experimental/investigational**, or does not meet our requirement for **medical necessity**, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

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

Any party whose appeal of an Adverse Determination is denied by BCBSTX may seek review of the decision by an IRO. BCBSTX will pay the cost of the IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative or **provider** of record information on how to appeal the denial, including the approved form, which you, your designated representative, or your **provider** of record must complete. In **life-threatening**, urgent care situations, the denial of a step therapy exception request, or if BCBSTX has discontinued coverage of **prescription drugs** or intravenous infusions for which you were receiving health **benefits** under this **policy**, you, your designated representative, or your **provider** of record may contact BCBSTX by telephone to request the review and provide the required information. For all other situations, you or your designated representative must sign the form and return to BCBSTX to begin the independent review process.

- BCBSTX will submit medical records, names of **providers** and any documentation pertinent to the decision of the IRO.
- BCBSTX will comply with the decision by the IRO.
- BCBSTX will pay for the independent review.

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

- Information relied upon to make the decision
- Information submitted, considered, or generated in the course of making the decision, whether or not it was relied upon to make the decision
- Descriptions of the administrative process and safeguards used to make the decision
- Records of any independent reviews conducted by BCBSTX
- Medical judgments, including whether a particular service is **experimental/investigational** or not **medically necessary** or appropriate
- Expert advice and consultation obtained by BCBSTX in connection with the denied **claim**, whether or not the advice was relied upon to make the decision

The appeal process does not prohibit you from pursuing other appropriate remedies, including civil action, injunctive relief, a declaratory judgment, or other relief available under law.

Assignment

At the request of the **covered person** or their parent or guardian, medical **benefits** may be paid to the **provider** of service. No assignment of **benefits** will be binding on us until a copy of the assignment has been received by the us or our administrator. We assume no responsibility for the validity of the assignment. Any payment made in good faith will end our liability to the extent of the payment.

Physical Examination and Autopsy

We have the right to have a **doctor** of our choice examine the **covered person** as often as is reasonably necessary. This section applies when a **claim** is pending or while **benefits** are being paid. We also have the right to request an autopsy in the case of death unless the law forbids it. Such examinations or autopsy will be at our expense.

Subrogation

We may recover any **benefits** paid under this **policy** to the extent a **covered person** is paid for the same **injury** or **sickness** by a third party, another insurer, or the **covered person's** uninsured motorist insurance. Our reimbursement may not be greater than the amount of the **covered person's** recovery. In addition, we have the right to offset future **benefits** payable to the **covered person** under this **policy** against such recovery.

We may file a lien in a **covered person's** action against the third party and have a lien against any recovery that the **covered person** receives whether by settlement, judgment, or otherwise. We shall have a right to recovery of the full amount of **benefits** paid under this **policy** for the **injury** or **sickness**, and that amount shall be deducted first from any recovery made by the **covered person**. We will not be responsible for the **covered person's** attorney fees or other costs.

Right of Recovery

If we make payments with respect to **benefits** payable under this **policy** in excess of the amount necessary, we shall have the right to recover such payments. We shall notify the **covered person** of such overpayment and request reimbursement from the **covered person**. However, should the **covered person** not provide such reimbursement, we shall have the right to offset such overpayment against any other **benefits** payable to the **covered person** under this **policy** to the extent of the overpayment.

ADMINISTRATIVE PROVISIONS

Premiums

The premiums for this **policy** will be based on the rates currently in force, the **plan** and amount of insurance in effect.

Changes in Premium Rates

We may change the premium rates from time to time with at least 60 days advanced written or authorized electronic or telephonic notice. No change in rates will be made until 12 consecutive months after this **policy** effective date. An increase in rates will not be made more often than once in a 12-month period. However, we reserve the right to change rates at any time if any of the following events take place:

- The terms of the **policy** change
- A division, subsidiary, affiliated organization, or eligible class is added or deleted from this **policy**
- There is a change in the factors bearing on the risk assumed
- Any federal or state law or regulation is amended to the extent it affects our **benefit** obligation

If an increase or decrease in rates takes place on a date that is not a premium due date, a pro rata adjustment will apply from the date of the change to the next premium due date.

Payment of Premium

The first premium is due on the **policy** effective date.

If any premium is not paid when due, the **policy** will be canceled as of the premium due date, except as provided in the **policy** grace period provision.

Policy Grace Period

A **policy** grace period of 31 days will be granted for the payment of the required premiums. The **policy** will remain in force during the grace period. If the required premiums are not paid during the **policy** grace period, insurance will end upon the expiration of the grace period. The **policyholder** will be liable to us for any unpaid premium for the time the **policy** was in force.

Reinstatement

If this **policy** terminates due to default in premium payment(s), the subsequent acceptance of such defaulted premium by us or any duly authorized agents shall fully reinstate this **policy**. For purposes of this section, mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of this **policy** shall not be deemed a waiver of either the requirement of timely premium payment or the right of termination for default in premium payment in the event of any future failure to make timely premium payments.

Currency

All premiums for and **claims** payable pursuant to this **policy** are payable only in the currency of the United States of America.

ParPlan Provider Arrangement

A **provider** who is not a **network provider** will be considered an **out-of-network provider**. An **out-of-network provider** may participate in a par plan arrangement, which is a simple direct-payment arrangement in which the **provider** agrees to:

- File all **claims** for the **covered person**
- Accept the **allowable amount** determination as payment for **medically necessary** services
- Not bill the **covered person** for services over the **allowable amount** determination.

Benefits will be subject to the out-of-network:

- **Deductible, copayment(s), coinsurance**
- Limitations and exclusions
- Maximums

Notice of Termination of PPO Arrangement with Network Providers

If we terminate a PPO arrangement with a **network provider**, proper notice will be sent to **covered persons** advising them of our termination and will make available a current listing of **network providers**. Our termination of a **network provider**, except for reasons of medical incompetence or unprofessional behavior, shall not release the **provider** from the generally recognized obligation to treat the continuing-care patient and to cooperate in arranging for appropriate referrals. Nor does it release us from the obligation to reimburse the **covered person** at the **network provider** rate if, at the time of our termination of the **network provider**, the **covered person** is a continuing-care patient. The continuity of coverage under this provision will not be extended beyond the earlier of 90 days or the date on which the **covered person** is no longer a continuing-care patient with respect to such **provider**.

A continuing-care patient means a **covered person** who:

- Is undergoing a course of treatment for a serious and complex condition from the **provider**
- Is undergoing a course of institutional or **inpatient** care from the **provider**
- Is scheduled to undergo non-elective **surgery** from the **provider**, including receipt of postoperative care from such **provider** with respect to such a **surgery**
- Is pregnant and undergoing a course of treatment for the pregnancy from the **provider**
- Is or was determined to be terminally ill and is receiving treatment for such illness from such **provider**

A serious and complex condition is:

- In the case of an acute **sickness**, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm
- In the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized **medical care** over a prolonged period of time

GENERAL PROVISIONS

Entire Contract

The entire contract consists of the **policy** (including any endorsements or amendments), the signed application of the **policyholder**, the **student** enrollment form, **benefit**, and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the **benefits**, or be used in defense of a **claim** for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of this **policy**, or to extend the time for payment of premiums, or to waive any of our rights or requirements. No modifications of this **policy** will be valid unless evidenced by an endorsement or amendment of this **policy**, signed by one of our officers and delivered to the **policyholder**.

Policy Effective Date

This **policy** begins on the **policy** effective date at 12:01 AM, Central Time at the address of the **policyholder**.

Policy Termination

We may terminate this **policy** by giving 31 days written (authorized electronic or telephonic) notice to the **policyholder**. Either we or the **policyholder** may terminate this **policy** on any premium due date by giving 31 days advance written (authorized electronic or telephonic) notice to the other. This **policy** may be terminated at any time by mutual written or authorized electronic/telephonic consent of the **policyholder** and us.

This **policy** terminates automatically on the earlier of:

- The **policy** termination date shown in this **policy**
- The premium due date if premiums are not paid when due
- The **policy** effective date of the renewal of this **policy** if a **student** decides to renew coverage under this **policy**, and the **policy** effective date of the renewal of this **policy** becomes effective before this **policy** terminates

Termination takes effect at 12:00 AM, Central Time at the address of the **policyholder** on the date of termination.

Premium Rebates, and Premium Abatements; and Cost-Sharing:

- **Rebate.** In the event federal or state law requires Blue Cross and Blue Shield to rebate a portion of annual premiums paid, Blue Cross and Blue Shield will provide any rebate as required or allowed by such federal or state law.
- **Abatement.** Blue Cross and Blue Shield may from time to time determine to abate (all or some of) the premium due under this **policy** for particular period(s). Any abatement of premium by Blue Cross and Blue Shield represents a determination by Blue Cross and Blue Shield not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this **policy**. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.

- Blue Cross and Blue Shield makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding, or reporting requirements). It will be the obligation of each person owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state, or local laws or regulations.
- **Cost-sharing.** Blue Cross and Blue Shield reserves the right from time to time to waive or reduce the **coinsurance**, **copayments** and/or **deductibles** under this **policy**.

Examination of Records and Audit

We shall be permitted to examine and audit the **policyholder's** books and records at any time during the term of this **policy** and within 2 years after final termination of this **policy** as they relate to the premiums or subject matter of this insurance.

Clerical Error

A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Legal Actions

No action at law or in equity may be brought to recover on this **policy** prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this **policy**. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Misstatement of Age

In the event the age of a **covered person** has been misstated, the premium rate for such person shall be determined according to the correct age as provided in this **policy** and there shall be an equitable adjustment of premium rate made so that we will be paid the premium rate at the true age for the **covered person**.

Conformity with State Statutes

Any provision of this **policy** which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Not in Lieu of Workers' Compensation

This **policy** is not a Workers' Compensation policy. It does not provide any Worker's Compensation benefit.

Information and Medical Records

All **claim** information, including, but not limited to, medical records, will be kept confidential and except for reasonable and necessary business use, disclosure of such confidential **claim** information would not be performed without the authorization of the **covered person** or as otherwise required or permitted by applicable law.

Proprietary Materials

The **policyholder** acknowledges that we have developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, **plans**, procedures, and information, all of which are proprietary information ("Business Proprietary Information"). The **policyholder** shall not use or disclose to any third-party Business Proprietary Information without our prior written consent. Neither party shall use the name, symbols, trademarks or service marks of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that we may include the **policyholder** in its list of clients.

SEPARATE FINANCIAL ARRANGEMENTS REGARDING PRESCRIPTION DRUGS

Separate Financial Arrangements with Network Prescription Drug Providers

The maximum amount of **benefits** payable and all required **deductible**, **copayment**, and **coinsurance** amounts under this contract shall be calculated on the basis of the **provider's** billed charge or the agreed upon cost between the network **prescription drug provider** as defined below, and us, whichever is less.

We hereby disclose that we have contracts, either directly or indirectly, with **prescription drug providers** ("Network Prescription Drug Providers") for the provision of, and payment for, **prescription drug** services to all **covered persons**.

The **policyholder** understands that we may receive such discounts during the term of the contract. Neither the **policyholder** nor **covered person** hereunder is entitled to receive any portion of any such discounts in excess of any amount that may be reflected in this **policy**.

Separate Financial Arrangements with Pharmacy Benefit Managers

We hereby inform the **policyholder** and all **covered persons** that it owns a significant portion of the equity of Prime Therapeutics LLC and that we have entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, **prescription drug benefits** to all **covered persons** entitled to **prescription drug benefits** under this **policy**.

Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. Pharmacy Benefit Managers may share a portion of those rebates with us.

The **policyholder** understands that we may receive such discounts during the term of the contract. Neither the **policyholder** nor **covered person** hereunder is entitled to receive any portion of any such discounts in excess of any amount that may be reflected in this **policy**.

Severability

In case any one or more of the provisions contained in this **policy** shall, for any reason, beheld to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this **policy** and this **policy** shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

Third Party Data Release

In the event a third party has access to confidential data, third party consultants must acknowledge and agree:

To maintain the confidentiality of the confidential information and any proprietary information (for purposes of this section, collectively, "Information").

The third-party consultant and/or vendor shall:

- Use the Information only for necessary business purposes
- Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the business need
- Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein
- Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information
- Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of this **policy** or as required by law
- Not use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use

The third-party consultant and/or vendor shall execute our then-current confidentiality agreement.

The third-party consultant and/or vendor shall be designated on the appropriate HIPAA documentation.

The **policyholder** shall indemnify, defend, and hold harmless us and our employees, officers, directors, and agents against any and all losses, liabilities, damages, penalties, and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of **claims**, lawsuits, demands, settlements or judgments brought against us in connection with any **claim** based upon our disclosure to the third party consultant and/or vendor of any information and/or documentation regarding any **covered person** at the direction of the **policyholder** or breach by the third party consultant and/or vendor of any obligation described in this **policy**.

Identity Theft Protection

As a **covered person**, BCBSTX makes available at no additional cost to you, identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSTX's designated outside vendor and acceptance or declination of these services is optional to the **covered person**. **Covered persons** who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbstx.com or by telephone by calling 1-800-521-2227. Services may automatically end when the person is no longer an eligible **covered person**. Services may change or be discontinued at any time with reasonable notice. BCBSTX does not guarantee that a particular vendor or service will be available at any given time.

Notice of Annual Meeting

The **policyholder** is hereby notified that it is a member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative or by proxy at all meetings of members of said **company**. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m. For purposes of the aforementioned paragraph the term "Member" means the group, trust, association, or other entity to which this **policy** has been issued. It does not include **covered persons** under this **policy**. Further, for purposes of determining the number of votes to which the **policyholder** may be entitled, any reference in this **policy** to "premium(s)" shall mean "charge(s)."

Service Mark Regulation

On behalf of the **policyholder** and its **covered persons**, the **policyholder** hereby expressly acknowledges its understanding that this **policy** constitutes a contract solely between the **policyholder** and us. We are an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits us to use the Blue Cross and Blue Shield Service Mark in our service area, and we are not contracting as the agent of the Association. The **policyholder** further acknowledges and agrees that it has not entered into this **policy** based upon representations by any person other than persons authorized by us and that no person, entity, or organization other than us shall be held accountable or liable to the **policyholder** for any of our obligations to the **policyholder** created under this **policy**. This paragraph shall not create any additional obligations whatsoever on our part, other than those created under other provisions of this **policy**.

Rescission of Coverage

We may not void coverage based on a misrepresentation by a **covered person** unless the **covered person** performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact with the intent to deceive the **plan** on the **covered person's** application; having done so will result in the cancellation of coverage for the **covered person** (and/or the **covered person's dependents or dependents'** coverage) retroactive to the effective date, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, Blue Cross and Blue Shield of Texas may deduct from the premium refund any amounts made in **claim payments** during this period and the **covered person** may be liable for any **claim payment** amount greater than the total amount of premiums paid during the period for which cancellation is affected.

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements

Out-of-Area Services

Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, herein called BCBSTX has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Agreements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you access healthcare services outside of BCBSTX service area, the **claims** for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program, and may include Negotiated Arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

When you receive care outside our service area, you will receive it from one of two kinds of **providers**. Most **providers** ("participating **providers**") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some **providers** ("non-participating healthcare **providers**") don't contract with the Host Blue. We explain how we pay both types of **providers** below.

A. BlueCard® Program

Under the BlueCard Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare **providers**.

For **inpatient** facility services received in a **hospital**, the Host Blue's participating **provider** is required to obtain **prior authorization**. If **prior authorization** is not obtained, the participating **provider** will be sanctioned based on the Host Blue's contractual agreement with the **provider**, and the member will be held harmless for the **provider** sanction.

Whenever you receive 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**
- 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 of claims, as noted above. However, such adjustments will not affect the price we use for your **claim** because they will not be applied after a **claim** has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

As an alternative to the BlueCard Program, your **claims** for covered healthcare services may be processed through a Negotiated 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 **providers**, the amount(s) you pay for such services will be calculated using the methodology described in this **policy** for non-participating **providers** located inside our service area. You may be responsible for the difference between the amount that the non-participating **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 **provider** on an exception basis. If a negotiated payment is not available, then the **plan** may make a payment based on the lesser of:

- The amount calculated using the methodology described in this **policy** for non-participating **providers** located inside your service area (and described in Section C(a)(1) above)
- The following:
    - For professional **providers**, an amount equal to the greater of the minimum amount required in the methodology described in this **policy** for non-participating **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
    - For **hospital** or facility **providers**, an amount equal to the greater of the minimum amount required in the methodology described in this **policy** for non-participating **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 **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. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the **plan** will include any such surcharge, tax or other fee as part of the **claim** charge passed on to you.

E. Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the **provider** incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSTX has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your **institution** on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

F. Blue Cross Blue Shield Global Core®

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 Blue Cross Blue Shield Global Core when accessing covered healthcare services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of **inpatient**, **outpatient** and professional **providers**, the network is not served by a Host Blue. As such, when you receive care from **providers** outside the 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.

- **Emergency Care Services**

  This contract covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include **emergency care** and urgent care obtained outside of the United States. Follow-up care following an emergency is also available, provided the services are **prior authorized** by BCBSTX. Any other services will not be eligible for **benefits** unless authorized by BCBSTX.

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, **hospitals** will not require you to pay for covered **inpatient** services, except for your cost-share amounts/**deductibles**, **coinsurance**, etc. In such cases, the **hospital** will submit your **claims** to the service center to begin **claims** processing. However, if you paid in full at the time of service, you must submit a **claim** to receive reimbursement for covered healthcare services.

- **Outpatient Services**

  Outpatient Services are available for the treatment of **emergency care** and urgent 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 healthcare services.

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

When you pay for covered healthcare 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 BCBSTX, 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.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life and Health Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited, and policyholders must meet certain guidelines to qualify. (The law is found in the Texas Insurance Code, Chapter 463.)

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company, which is a member of the Association, is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

Residents of Texas at the time that their insurance company is impaired. Residents of other states, ONLY if the following conditions are met:

- The policyholder has a policy with a company based in Texas
- The company has never held a license in the policyholder's state of residence
- The policyholder's state of residence has a similar guaranty association
- The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence

Limits of Protection by the Association Health Insurance:

Up to a total of $500,000 for one or more policies for each individual covered.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, Texas 78701 800-982-6362 www.txlifega.org	Texas Department of Insurance P.O. Box 149104 Austin, Texas 78714-9104 800-252-3439

EXHIBIT A. PLAN SERVICE AREA LISTING
APPLICABLE ONLY TO MANAGED HEALTH CARE BENEFIT COVERAGE
(In-Network and Out-of-Network Benefits)

STATE	BLUE CROSS AND BLUE SHIELD PLAN	PLAN SERVICE AREA
Alabama	Blue Cross and Blue Shield of Alabama	State-wide
Alaska	Blue Cross of Washington and Alaska (Premera)	State-wide
Arizona	Blue Cross and Blue Shield of Arizona	State-wide
Arkansas	Arkansas Blue Cross and Blue Shield	State-wide
California	Blue Shield of California Blue Cross of California	State-wide
Colorado	Blue Cross and Blue Shield of Colorado	State-wide
Connecticut	Anthem Blue Cross and Blue Shield (Connecticut)	State-wide
Delaware	Blue Cross and Blue Shield of Delaware	State-wide
District of Columbia	Care First Blue Cross and Blue Shield (DC)	State-wide (Maryland only)
Florida	Blue Cross and Blue Shield of Florida (BlueCard PPO Network)	State-wide
Georgia	Blue Cross and Blue Shield of Georgia	State-wide
Hawaii	Blue Cross and Blue Shield of Hawaii	State-wide
Idaho	Blue Cross of Idaho Regence Blue Shield of Idaho	State-wide
Illinois	Blue Cross and Blue Shield of Illinois	State-wide
Indiana	Anthem Blue Cross and Blue Shield (Indiana)	State-wide
Iowa	Wellmark Blue Cross and Blue Shield of Iowa	State-wide
Kansas	Blue Cross and Blue Shield of Kansas	State-wide, excluding Johnson and Wyandotte Counties
Kentucky	Anthem Blue Cross and Blue Shield (Kentucky)	State-wide
Louisiana	Blue Cross and Blue Shield of Louisiana (Preferred Care PPO Network)	State-wide
Maine		State-wide
Maryland	Care First BlueCross and BlueShield (Maryland)	State-wide
Massachusetts	Blue Cross and Blue Shield of Massachusetts	State-wide
Michigan	Blue Cross and Blue Shield of Michigan	State-wide
Minnesota	Blue Cross and Blue Shield of Minnesota	State-wide
Mississippi	Blue Cross and Blue Shield of Mississippi	State-wide
Missouri	Blue Cross and Blue Shield of Kansas City (Preferred Care Network) Alliance Blue Cross and Blue Shield (St. Louis)	State-wide
Montana	Blue Cross and Blue Shield of Montana	State-wide
Nebraska	Blue Cross and Blue Shield of Nebraska	State-wide
Nevada	Blue Cross and Blue Shield of Nevada	State-wide
New Hampshire	Blue Cross and Blue Shield of New Hampshire	State-wide
New Jersey	Horizon Blue Cross and Blue Shield of New Jersey	State-wide
New Mexico	Blue Cross and Blue Shield of New Mexico	State-wide

New York	Empire Blue Cross and Blue Shield Blue Cross and Blue Shield of Western New York Blue Shield of Northeastern New York Blue Cross and Blue Shield of Rochester Area Blue Cross and Blue Shield of Central New York Blue Cross and Blue Shield of Utica-Watertown	State-wide
North Carolina	Blue Cross and Blue Shield of North Carolina (Preferred Care Select Network)	State-wide
North Dakota	Blue Cross and Blue Shield of North Dakota	State-wide
Ohio	Anthem Blue Cross and Blue Shield (Ohio) (Community Preferred Health Plan Network)	State-wide
Oklahoma	Blue Cross and Blue Shield of Oklahoma	Metropolitan areas of Oklahoma City and Tulsa, Lawton, Edmond, Shawnee, Hugo, Tahlequah, Cushing, Poteau, Pryor, and some other communities
Oregon	Regence Blue Cross and Blue Shield of Oregon	State-wide
Pennsylvania	Capital Blue Cross Independence Blue Cross Highmark Blue Cross and Blue Shield (Independence Blue Cross, Capital Blue Cross and Blue Cross of Northeastern Pennsylvania) Highmark Blue Cross and Blue Shield Blue Cross of Northeastern Pennsylvania	State-wide
Rhode Island	Blue Cross and Blue Shield of Rhode Island	State-wide
South Carolina	Blue Cross and Blue Shield of South Carolina	State-wide
South Dakota	Wellmark Blue Cross and Blue Shield of South Dakota	State-wide
Tennessee	Blue Cross and Blue Shield of Tennessee	State-wide
Texas	Blue Cross and Blue Shield of Texas	State-wide
Utah	Regence Blue Cross and Blue Shield of Utah	State-wide
Vermont	Blue Cross and Blue Shield of Vermont	State-wide
Virginia	Anthem Blue Cross and Blue Shield of South East	State-wide, exclusive of Amherst, Appomattox, Campbell, Culpeper counties and the city of Lynchburg
Washington	Premera Blue Cross Regence Blue Shield Northwest Washington Medical Bureau	State-wide
West Virginia	Mountain State Blue Cross and Blue Shield	State-wide
Wisconsin	Blue Cross and Blue Shield United of Wisconsin	State-wide
Wyoming	Blue Cross and Blue Shield of Wyoming	Laramie County Only
Puerto Rico	TRIPLE S and La Cruz Azul de Puerto Rico	Island-wide

BlueCross BlueShield of Texas

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

bcbstx.com TX1557_ENG_20250410

BlueCross BlueShield of Texas

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.