



**BlueCross BlueShield
of Texas**

Blue Choice Gold PPO-011

Blue Cross and Blue Shield of Texas (*herein called "BCBSTX, We, Us, Our"*)
Preferred Provider Plan providing Comprehensive Major Medical Coverage

REQUIRED OUTLINE OF COVERAGE

- I. Read Your Policy Carefully.** This Outline of Coverage provides a very brief description of some important features of Your Policy. This is not the insurance Policy and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of You, Your Physician or Professional Other Provider and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!**

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

Please note that for Child-Only coverage no additional Dependents may be added to Your Policy.

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

- II.** This Policy is designed to provide You with coverage for major hospital, medical, and surgical expenses that You incur for necessary treatment and services rendered as the result of a covered injury or Sickness.

Coverage is provided for the benefits outlined in Paragraph III. The benefits described in Paragraph III may be limited by Paragraph IV.

- III. Benefits.** We have a network of Providers to serve Participants throughout Texas called the Blue Choice PPOSM Network. When You use these Providers, You receive Network Benefits. To get a current directory or inquire about a Network Provider, call the Customer Service telephone number shown on the back of Your Identification Card or You may visit Our at website www.bcbstx.com.

Providers not listed in the directory are called Out-of-Network Providers. When You use these Providers, You will receive Out-of-Network Benefits except in special situations as explained in Your Policy.

Hereafter, Dependent child, child or children means a child who has been determined to be eligible for coverage, who is covered under this Policy. And who is a natural child of the Subscriber, a stepchild, a legally adopted child of the Subscriber (including a child for whom the Subscriber is a party in a suit in which the adoption of the child is being sought) or an eligible foster child, under twenty-six (26) years of age, regardless of the presence or absence of a child's financial dependency, residency, student status, employment status, marital status, or any combination of those factors. An unmarried grandchild must be dependent on the Subscriber for Federal income tax purposes at the time application for coverage to be eligible for coverage under the Policy

- A. Benefit Period** – Your Benefit Period is a Calendar Year (begins January 1 and ends December 31).

- B. **Deductible** – The Calendar Year Deductible, if applicable, will be subtracted once during each Calendar Year from each Participant’s total Eligible Expenses. A Deductible will apply to each Hospital Admission of a Participant. The amount of Your Deductibles will be as shown below:

Benefits	Network Benefits	Out-of-Network Benefits
Calendar Year Deductibles Individual	\$1,000	\$2,000
Family	\$3,000	\$6,000
Inpatient Hospital Deductible per Hospital Admission	\$200	\$300

- C. **Copayment Amount** – The Copayment Amount will be required.

Benefits	Network Benefits	Out-of-Network Benefits
Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians	\$30 Primary Care Copayment Amount	60% of the Allowable Amount after Calendar Year Deductible
Specialty Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider.	\$50 Specialty Copayment Amount	60% of the Allowable Amount after Calendar Year Deductible
Outpatient surgery Copayment Amount (facility charges only)	\$150	\$250
Outpatient Hospital emergency room/treatment room visit	\$400	\$400

- D. **Preauthorization** – Preauthorization is required for all Hospital Admissions, *Extended Care Expense*, Home Infusion Therapy, organ and tissue transplants and certain Behavioral Health Services. You, Your Physician or Professional Other Provider or a family member must call the toll-free telephone number listed on the back of the Identification Card.

When a Hospital Admission is preauthorized, a length-of-stay is assigned. This Policy provides a minimum length-of-stay in a Hospital for the following:

Maternity Care

- 48 hours following an uncomplicated vaginal delivery
- 96 hours following an uncomplicated delivery by Caesarean section.

Treatment of Breast Cancer

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

Failure to preauthorize will result in a \$500 penalty for Hospital Admission, organ and tissue transplants and certain Behavioral Health Services. A penalty in the amount of 50% not to exceed \$500 will apply to *Extended Care Expense* or Home Infusion Therapy for failure to preauthorize.

- E. **Eligible Expenses** – After the applicable Deductible(s), if any, are met, Your coverage pays 80% of the Allowable Amount for Eligible Expenses provided by a Network Provider and 60% of the Allowable Amount for Eligible Expenses rendered by an Out-of-Network Provider, subject to other provisions of the Policy. The remainder of these Eligible Expenses becomes “Coinsurance Amounts” and must be paid by You.

Additionally, the Allowable Amount for Out-of-Network Emergency Care and care provided by an Out-of-Network Provider when a Network Provider is not reasonably available to an insured will be no less than the amount required by Texas law and regulations.

IMPORTANT TO YOUR COVERAGE

To pay less out-of-pocket expenses and to receive the higher level of benefits for Your health care costs, it is to Your advantage to use Network Providers. If You use Network Providers, You will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much You would pay if you use a Network Provider and how much You would pay if You use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same. (NOTE: In most cases, however, the non-contracting Allowable Amount will be less than the contracting Allowable Amount Your total payment responsibility will be even greater.)

EXAMPLE ONLY	In-Network	Out-of-Network
	80% of eligible charges \$500 Deductible	60% of eligible charges \$1,000 Deductible
Amount Billed	\$20,000	\$20,000
Allowable Amount	\$5,000	\$5,000
Deductible Amount	\$500	\$1,000
Plan’s Coinsurance Amount	\$3,600	\$2,400
Your Coinsurance Amount	\$900	\$1,600
Non-Contracting Provider’s additional charge to you	None	\$15,000 ¹
YOUR TOTAL PAYMENT	\$1,400 to a Network Provider	\$17,600 to a Non-contracting Out-of-Network Provider

Even when You consult a Network Provider, ask questions about any of the Providers rendering care to You. For example, if You are scheduled for surgery, ensure that Your Network surgeon will be using a Network facility for Your procedure and a Network Provider for Your anesthesia services.

¹ If You choose to receive services from an Out-of-Network Provider, inquire if he participates in a contractual arrangement with BCBSTX. Providers who do not contract with BCBSTX or any other Blue Cross and Blue Shield plan may bill the patient for expenses over the Allowable Amount. Please refer to the section entitled *PARPLAN* in the Policy.

1. **Inpatient Hospital Expense:**

- An Inpatient Hospital Deductible will apply to each Hospital Admission.
- For a preauthorized Hospital Admission, room and board charges. If You stay in a private room, only the Hospital’s average semi-private room rate will be considered for benefits.
- Intensive care and coronary care units.
- All other usual Hospital services and supplies.

2. **Medical-Surgical Expense:**

- Services of Physicians, Professional Other Providers, and certified registered nurse-anesthetists (CRNA).
- Physical Medicine Services (therapies) up to 35 visits per Calendar Year. Benefits used in Network and Out-of-Network will apply toward satisfying any visit limit.
- Diagnostic x-ray, laboratory procedures, and radiation therapy.
- Maternity Care.
- Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Amino acid-based elemental formulas.
- Rental of durable medical equipment (DME) required for therapeutic use (does not include such items as air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment).
- Emergency Medical Transportation to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.
- Anesthetics and administration when performed by someone other than the operating Physician or Professional Other Provider.
- Oxygen and its administration provided the oxygen is used.
- Blood, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for the Participant.
- Prosthetic Appliances, including replacements and repairs of such devices other than those required by misuse or loss by the Participant.
- Orthotic Devices that are consistent with the Medicare Benefits Policy Manual.
- Orthopedic braces and crutches.
- Home Infusion Therapy.
- Services or supplies received during an outpatient visit to a Hospital.
- Outpatient Surgery (an Outpatient Surgery Copayment Amount will apply to the facility charges).
- Diabetic Equipment and Supplies as described in the Policy.
- Outpatient Contraceptive Services and prescriptive contraceptive devices. However, coverage for prescription oral contraception medications is provided under the Pharmacy Benefits.
- Telehealth services and telemedical medicine services.

3. **Extended Care Expense** - Benefits will require Preauthorization and will be available for:

- Skilled Nursing Facility – up to 25 days per Calendar Year;
- Home Health Care – up to 60 visits per Calendar Year; and
- Hospice Care - unlimited.

Benefits used in Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year maximum amounts indicated.

4. **Childhood Immunizations** – Childhood immunizations are available for a Dependent child from birth through age 6 at 100% of the Allowable Amount for Network and Out-of-Network Benefits. The Deductible, if any, will not apply.

5. ***Preventive Care*** – Benefits will be provided for the following Covered Services:

- 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 for Participants 7 years of age and over recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
- with respect to women, such additional preventive care and screenings, not described in the first bullet item above, as provided for in comprehensive guidelines supported by the HRSA.

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

Examples of preventive covered services included are well child care, routine physical, routine laboratory procedures, adult immunizations, hearing screening, routine mammograms, routine bone density test, colorectal cancer screenings, prostate cancer screenings, HPV/cervical cancer screenings, healthy diet counseling, obesity screening/counseling and smoking cessation counseling.

Examples of covered immunizations include Diphtheria, Hemophilus influenzae type b, Hepatitis A, Hepatitis B, Human papillomavirus, influenza, Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Polio, Rotavirus, Rubella, Tetanus, Varicella, and any other immunization that is required by law. Allergy injections are not considered immunizations under this benefit provision.

The Preventive Care Services and immunizations described in this section 4 may change as the USPSTF, CDC, and HRSA guidelines are modified. For more information You may visit Our website at www.bcbstx.com or call the Customer Service at the telephone number shown on Your Identification Card.

Covered Services not included in this section 4 will be subject to any applicable Deductible, Coinsurance Amount, Copayment Amount and/ or dollar maximums.

Benefits for Outpatient Contraceptive Services

Benefits for Eligible Expenses incurred for the following Outpatient Contraceptive Services received from a Network Provider will not be subject to Copayment Amounts, Coinsurance Amounts and any applicable Deductibles or dollar maximums:

Benefits will be provided to women with reproductive capacity for specified drugs and devices in each of the following categories of FDA approved contraceptive drugs and devices, including certain: progestin-only contraceptives; combination contraceptives; emergency contraceptives; extended-cycle/continuous oral contraceptives; cervical caps; diaphragms; implantable contraceptives; intra-uterine devices; injectables; transdermal contraceptives and vaginal contraceptive devices. The contraceptive drugs and devices listed above may change as FDA guidelines, medical management and medical policies are modified. NOTE: Prescription contraceptive medications are covered under the Your Pharmacy Benefits section of the Policy.

Contact Customer Service at the toll-free number on your Identification Card to determine what contraceptive drugs and devices are covered under this benefit provision.

Contraceptive drugs and devices not covered under this benefit provision may be covered under other sections of the Policy subject to any applicable Coinsurance Amount, Copayment Amount, Deductibles and/or benefit maximum.

Benefits will be provided for female sterilization procedures for women with reproductive capacity and Outpatient Contraceptive Services. Also, benefits will be provided for FDA approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner. The Participant will be responsible for submitting a claim form with the written prescription and itemized receipt for the female over-the-counter contraceptive. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form

Benefits for the above listed services received from Out-of-Network Providers or non-Participating Pharmacies may be subject to any applicable Deductible, Coinsurance Amount, Copayment Amount and/or benefit maximum.

Benefits for Breastfeeding Support, Services and Supplies

Benefits for Eligible Expenses incurred for Breastfeeding Support, Services and Supplies received from a Network Provider will not be subject to Copayment Amount, Coinsurance Amount and any applicable Deductibles or dollar maximums.

Benefits will be provided for breastfeeding counseling and support services rendered by a Provider during pregnancy and/or in the post-partum period.

Benefits will also be provided for the rental (or at Our option, the purchase) of manual, or electric breast pumps or the rental only of a Hospital grade breast pump and supplies. You may be required to pay the full cost for the rental (or purchase) of a manual or electric breast pump or the rental only of a Hospital grade breast pump and supplies and submit a claim form to Us with a written prescription and itemized receipts. Visit the BCBSTX website at www.bcbstx.com for to obtain a claim form.

Contact Customer Service at the toll-free number on your Identification Card for additional information on the benefits covered under this provision.

If you use an Out-of-Network Provider, the benefits may be subject to any applicable Deductible, Coinsurance Amount, Copayment Amount and/or benefit maximum.

Network Benefits	Out-of-Network Benefits
100% of the Allowable Amount	60% of the Allowable Amount after Calendar Year Deductible

6. **Newborn Screening Tests for Hearing Impairment**— Screening tests for hearing loss from birth through the date the Dependent child is 30 days old; and necessary diagnostic follow-up care related to the screening test from birth through the date the Dependent child is 24 months old.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount	60% of the Allowable Amount

7. **Benefits for Autism Spectrum Disorder** - Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant’s Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are available for a covered Dependent child from birth but who has not yet reached the age of ten.

For purposes of the provision, generally recognized services may include services such as:

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

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

After the Dependent child reaches the age of ten, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, Preauthorization and benefit maximums.

8. **Certain Therapies for Children with Developmental Delays** – Benefits are provided for a Dependent child under three years of age with developmental delays for the necessary rehabilitative and habilitative therapies in accordance with an *individualized family service plan* issued by the Texas Interagency Council on Early Childhood Intervention. Such therapies include occupational therapy evaluation and services; physical therapy evaluations and services; speech therapy evaluations and services; and dietary or nutritional evaluations.

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

9. **Benefits for Early Detection Tests for Cardiovascular Disease** - One of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function:

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

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

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after Calendar Year Deductible	60% of the Allowable Amount after Calendar Year Deductible
Benefits are limited to one (1) screening every five (5) years per Participant.	

- F. **Out-of-Pocket Limit**— When a Participant’s cumulative dollar amount of Eligible Expenses, including the Calendar Year Deductible, incurred during a Calendar Year equals the amounts shown below, the benefit percentages change to 100% for the remainder of that Calendar Year.

Options	Network Out-of-Pocket Limit	Out-of-Network Out-of-Pocket Limit
Individual	\$3,000	\$6,000
Family	\$9,000	\$18,000

G. Emergency Services Benefits — Benefits are available for Emergency Services as follows:

Benefits	Network Benefits	Out-of-Network Benefits
Accident & Medical Emergency <ul style="list-style-type: none"> ▪ Facility Charges ▪ Physician Charges 	<p>80% of Allowable Amount after \$400 Outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible</p> <p>80% of Allowable Amount and after Calendar Year Deductible</p>	
Non-Emergency Situations <ul style="list-style-type: none"> ▪ Facility Charges ▪ Physician Charges 	<p>80% of Allowable Amount after \$400 Outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible</p> <p>80% of Allowable Amount after Calendar Year Deductible</p>	<p>60% of Allowable Amount after \$400 Outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible</p> <p>60% of Allowable Amount after Calendar Year Deductible</p>

H. Behavioral Health Services - Treatment of Chemical Dependency / Serious Mental Illness / Mental Health Care — Benefits are available for treatment as follows. Certain services will require Preauthorization:

Benefits	Network Benefits	Out-of-Network Benefits
Inpatient Services <ul style="list-style-type: none"> ▪ Inpatient treatment must be provided in a Chemical Dependency Treatment Center / Hospital services (facility) ▪ Behavioral Health Practitioner services 	<p>80% of Allowable Amount after \$200 Inpatient Hospital Deductible and after Calendar Year Deductible</p> <p>80% of Allowable Amount after Calendar Year Deductible</p>	<p>60% of Allowable Amount after \$300 Inpatient Hospital Deductible and after Calendar Year Deductible</p> <p>60% of Allowable Amount after Calendar Year Deductible</p>
Outpatient Services <ul style="list-style-type: none"> ▪ Behavioral Health Practitioner expenses (office setting) ▪ Other outpatient services 	<p>\$30 Primary Care Copayment Amount</p> <p>80% of Allowable Amount after Calendar Year Deductible</p>	<p>60% of Allowable Amount after Calendar Year Deductible</p> <p>60% of Allowable Amount after Calendar Year Deductible</p>

I. Pharmacy Benefits, including Mail Order Pharmacy

Copayment or Coinsurance Amounts

The Copayment or Coinsurance Amounts for Covered Drugs filled by a Participating Pharmacy, Non-Participating Pharmacy or a mail-order Pharmacy are shown below. If the Allowable Amount of the Covered Drug is less than the Copayment or Coinsurance Amount, the Participant will pay the lower cost.

Injectable drugs for subcutaneous self-administration are also covered by the Policy and are subject to the applicable Copayment or Coinsurance Amount. Injectable drugs include, but are not limited to insulin and Imitrex.

Payment of benefits covered under this Policy may be denied if drugs are dispensed or delivered in a manner intended to change or having the effect of changing or circumventing, the 90-day maximum quantity limitation (for instance, if You obtain multiple refills for the same Prescription Order before the original supply is consumed).

Member Pays the Difference

If You choose to buy the brand name drug when a Generic Drug is available, You will pay the Non-Preferred Brand Name Drug Copayment Amount **plus** the pricing difference between the Generic Drug and the Non-Preferred Brand Name Drug.

PHARMACY BENEFITS		
	Participating Pharmacy Participant pays...	Non-Participating Pharmacy Participant pays...
Retail Pharmacy 30-Day Supply	No Copayment Amount - preferred- Generic Drug \$10 Copayment Amount – non-preferred Generic Drug \$50 Copayment Amount – Preferred Brand Name Drug \$100 Copayment Amount* – Non-Preferred Brand Name Drug	50% of Allowable Amount** – preferred Generic Drug 50% of Allowable Amount** – non-preferred Generic Drug 50% of Allowable Amount** – Preferred Brand Name Drug 50% of Allowable Amount** – Non-Preferred Brand Name Drug*
Retail Pharmacy Extended Supply*** One Copayment Amount per 30- day supply, up to a 90-day supply	No Copayment Amount - preferred- Generic Drug \$10 Copayment Amount – non-preferred Generic Drug \$50 Copayment Amount – Preferred Brand Name Drug \$100 Copayment Amount* – Non-Preferred Brand Name Drug	50% of Allowable Amount** – preferred Generic Drug 50% of Allowable Amount** – non-preferred Generic Drug 50% of Allowable Amount** – Preferred Brand Name Drug 50% of Allowable Amount** Non-Preferred Brand Name Drug*
Mail Service 90-Day Supply	No Copayment Amount – preferred Generic Drug \$20 Copayment Amount – non-preferred Generic Drug \$100 Copayment Amount – Preferred Brand Name Drug \$200 Copayment Amount* – Non-Preferred Brand Name Drug	

Specialty Drugs Available in Network through Specialty Pharmacy Program	Specialty Pharmacy Provider Participant pays	Other Pharmacy Participant pays
Specialty Drugs 30-Day Supply	\$150 Copayment Amount - Specialty Drug	50% of Allowable Amount** – Specialty Drug
	Select Participating Pharmacy Participant pays	Non-Participating Pharmacy Participant pays
Vaccinations obtained through Pharmacies****	No Copayment Amount	50% of Allowable Amount

* If you receive a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Your Pharmacy Benefits section of your Policy for details.

** plus any applicable Copayment Amount or Coinsurance Amount and any applicable pricing differences.

*** If allowed by Prescription Order

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

To get the most out of your coverage, it is important that you carefully read the **Your Pharmacy Benefits and Limitations and Exclusions** sections of your Policy so You are aware of Policy requirements, provisions, limitations and exclusions. There are provisions concerning Quantity Limits, Preauthorization and Specialty Drugs.

IV. Limitations and Exclusions

Benefits of the medical portion of the Policy are not available for:

- Services or supplies not Medically Necessary for the treatment of a Sickness, injury, condition, disease, or bodily malfunction; any Experimental/Investigational services and supplies.
- Any charges more than the Allowable Amount as determined by Us.
- Any services and supplies for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law; or any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or any laws, regulations or established procedures of any county or municipality, except as provided in Article VIII, Section 8. This Subsection c shall not be applicable to any legislation, which specifies that the benefits of this Policy shall be deducted from the benefits available under such legislation.
- Charges for services and supplies provided which require Our approval when approval is not given.
- Services or supplies for which You are not required to make payment or for which You are not legally required to pay without this or any similar coverage, (**except** treatment of mental illness or mental retardation by a tax supported institution).
- Any services or supplies provided by a person who is related to You by blood or marriage.
- Treatment of injury or Sickness because of war, acts of war, or while on active or reserve military duty.

- Any charges because of suicide or attempted suicide.
- Charges resulting from failure to keep a scheduled visit with a Physician or Professional Other Provider, for completion of any insurance forms, or for acquisition of medical records unless requested and received by Us.
- Room and board charges during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been done on an outpatient basis.
- Services or supplies provided during a Hospital Admission or an admission in a Facility Other Provider beginning before the patient's Effective Date, or services or supplies provided after the termination of the Participant's coverage, **except** as provided in the Policy.
- Dietary and nutritional services, **except** as may be provided in the Policy for (1) a nutritional assessment program provided in and by a Hospital and approved in advance by Us; (2) *Treatment of Diabetes*; (3) *Certain Therapies for Children with Developmental Delay* and (4) *Autism Spectrum Disorder*.
- Custodial Care.
- Routine physical examinations, unless specifically stated in the Policy.
- Services or supplies (**except** Medically Necessary diagnostic and/or surgical procedures) for treatment of the jaw bone joints, muscles, or their related structures with appliances or splints, physical therapy, or alteration to eliminate pain or dysfunction.
- Services or supplies provided to correct congenital, developmental or acquired deformities of the jaw bone after a Participant's 19th birthday.
- Any items of *Medical-Surgical Expense* provided for dental care and treatments, dental surgery, or dental appliances, **except** (1) Oral Surgery as defined in the Policy, (2) congenital defects of a dependent child, or (3) services made necessary by Accidental Injury.
- Cosmetic, Reconstructive or Plastic Surgery unless caused by injury, congenital defects of a dependent child, reconstructive surgery following cancer surgery; reconstructive surgery following mastectomy; surgery and reconstruction of the other breast to achieve symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.
- Any services or supplies, except for benefits provided by Pediatric Vision Care Benefits attached to this Policy, provided for: 1) Treatment of myopia and other errors of refraction, including refractive surgery; or 2) Orthoptics or visual training; or 3) Eyeglasses, contact lenses or hearing aids, provided that intraocular lenses and cochlear implant devices shall be specific exceptions to this exclusion; or 4) Examinations for the prescription or fitting of eyeglasses, contact lenses or hearing aids, **except** as may be provided for in the **Special Benefit Provisions** section in **Article IV – Your Medical Benefits** of the Policy.
- Any services or supplies provided by a Licensed Hearing Instrument Aid Fitter and Dispenser.
- Except as specifically provided for in the Policy, any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling; any services or supplies provided by a Licensed Clinical Social Worker, a Licensed Professional Counselor, or a Marriage and Family Therapist.
- Treatment of adolescent behavior disorders, including conduct disorders and oppositional disorders.
- Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the *Benefits for Autism Spectrum Disorder* provision and the *Benefits for Physical Medicine Services* provision in the **Special Benefit Provisions** of the Policy.
- Travel, whether recommended by a Physician or Professional Other Provider, **except** Emergency Medical Transportation as provided in the Policy.
- Treatment of obesity or weight, including surgical procedures, even if other health conditions might be helped by the reduction. This exclusion does not apply to healthy diet counseling or obesity screening/counseling.

- Any services or supplies for inpatient allergy testing, or any testing or treatment for environmental sensitivity or clinical ecology, or any treatment not recognized as safe and effective.
- Any services or supplies provided with chelation therapy **except** treatment of acute metal poisoning.
- Any services or supplies for sterilization reversal (male or female), transsexual surgery, sexual dysfunction, in vitro fertilization services, or artificial insemination.
- Routine foot care as described in the Policy.
- Any Speech and Hearing Services **except** as provided in the Policy for (1) *Extended Care Expense*, (2) *Preventive Care*; (3) *Newborn Screening Tests for Hearing Impairment*; (4) *Certain Therapies for Children with Developmental Delay* and (5) *Autism Spectrum Disorder*.
- Any services or supplies for reduction mammoplasty.
- Services or supplies for acupuncture, videofluoroscopy, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
- Orthodontic or other dental appliances; splints or bandages provided by a Physician in a non-hospital setting or purchased “over-the-counter” for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts, **except** for podiatric appliances when provided in conjunction with treatment of diabetes.
- Services or supplies provided for or in conjunction with conditions, which have been specifically excluded for a Participant.
- Any drugs and medicines, **except as may be** provided under the Pharmacy Benefits, that are: (1) dispensed by a Pharmacy and received by the Participant while covered under this Policy, (2) injected, ingested or applied in a Provider’s office or during confinement in a Hospital or other acute care institution or facility and received by the Participant for use on an outpatient basis, (3) over-the-counter drugs and medicines; or drugs for which no charge is made, (4) prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, or (5) Retin-A or pharmacological similar topical drugs.
- Any male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide, when not prescribed by a Health Care Practitioner.
- Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies or drugs.
- Any services or supplies not specifically defined as Eligible Expenses in the Policy.

The benefits provided under the Pharmacy Benefits are not available for:

- Drugs which do not by law require a Prescription Order from a Provider or authorized Health Care Practitioner (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies as shown on your Schedule of Coverage); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.
- Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraceptive devices and the rental or at Our option, the purchase of a manual or electric breast pump are provided under the Your Medical Benefits portion of this Policy.
- Administration or injection of any drugs.

- Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
- Drugs injected, ingested or applied in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this item shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy..
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Coinsurance Amount or Copayment Amount provided under the Policy.
- Infertility medications and fertility medications; prescription contraceptive devices, non-prescription contraceptive materials (**except** prescription oral contraceptive medications which are Legend Drugs). However, coverage for prescription contraceptive devices is provided under the medical portion of the Policy.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Specialty Drugs, unless obtained through the *Specialty Pharmacy Program*.
- Any male contraceptive devices, including over-the-counter contraceptive products such as condoms; female contraceptive devices that do not require a prescription, including over-the-counter contraceptive products such as condoms and spermicide, when not prescribed by a Health Care Practitioner.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA).
- Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting; drugs given through routes other than subcutaneously in the home setting. This exception does not apply to dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. This exception also does not apply to amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins, severe food protein-induced enterocolitis syndromes, eosinophilic disorders, as evidenced by the results of biopsy and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. A Prescription Order from your Health Care Practitioner is required.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs, the use or intended use of, which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.

- Drugs used or intended to be used in the treatment of a condition, Sickness, disease, injury, or bodily malfunction which is not covered under the Program, or for which benefits have been exhausted.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) , in the same strength, unless otherwise determined by BCBSTX.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
- 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.)
- Some equivalent drugs are manufactured under multiple brand-names. In such cases, BCBSTX may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this Plan, the brand name drug purchases will not be covered under any benefit level. A list of brand or generic medications with lower cost therapeutic alternatives may exist.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Prescription drugs required for international travel or work.
- Drugs which are repackaged by a company other than the original manufacturer.

V. Renewability

This Policy is Guaranteed Renewable.

- A. Your and your Dependents' coverage will be terminated due to the following events and will end on the dates specified below:
 - When BCBSTX does not receive the full premium payment on time or when there is a bank draft failure of premiums subject to the Grace Period provided in **Article VIII – General Provisions**; or
 - On the Policy Date for fraudulent or intentional misrepresentation of a material fact that results in Rescission of the Policy; or
 - On the date of death of the Subscriber; or
 - On the date You no longer reside, live or work in the geographic area "network service area" designated by the Policy. You may call Customer Service at the number shown on the back of Your Identification Card to determine if You are in the network service area or You may visit Our website at www.bcbstx.com.

- B. We have the right to cancel this Policy after 90 days notice to You but only if all Policies of this particular type of individual coverage are being canceled provided We act uniformly without regard to any Health-Status Related Factor of covered individuals and each Participant shall have the option to purchase on a guaranteed issue basis any other individual health insurance policy We offer at the time of discontinuance of this Policy.

- C. If We cancel this Policy as stated in Section B, above, a Participant does not elect to purchase another hospital, medical or surgical policy, and if he is totally disabled on the cancellation date as described in Section B, above, coverage continues and shall be limited to: (1) the duration of the Benefit Period; (2) payment of maximum Policy benefits; or (3) a period not less than 90 days.
- D. We may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if We:
- Notify the Texas Department of Insurance Commissioner not later than 180 days prior to the date coverage under the first individual hospital, medical or surgical health benefit plan terminates;
 - Notify each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and
 - Act uniformly without regard to any Health-Status Related Factor of covered individuals or Dependents of covered individuals who may become eligible for coverage.

VI. Premiums

- A. The initial premium rate for Your Plan selection under this Policy is:
- Preferred category is \$_____.
 - Standard category is \$_____.

Premiums are due on the first day of each Policy Month.

- B. The premium rates for this Policy are established based on a number of factors such as the age of the Subscriber, place of residence, tobacco use, and the number covered under the Policy. We have the right to increase premiums after 60 days notice to You. Your premium will not be adjusted more often than annually except for:
1. in connection with changes to or as otherwise expressly permitted by state or federal laws and regulations; or
 2. changes to coverage classification (for example, to a new age category or geographic location, tobacco use, or from a single family member coverage to a two family member coverage type), or
 3. as otherwise permitted by this Policy.

No eligibility rules or variations in premiums will be imposed based on Your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or an other health status-related factor.

If both husband and wife are included on the same membership, the Subscriber's premium will be based on the age of each adult

- C. Except as provided below, a Grace Period is provided for each premium payment. A Grace Period of 31 days will be granted for the payment of each premium falling due after the first premium, during which Grace Period the Policy shall continue in force. After a Grace Period of 31 days, coverage under this Policy will automatically terminate on the last day of the coverage period for which premiums have been paid.

Texas Department of Insurance Notice

- You have the right to an adequate network of preferred providers (also known as “network providers”).
 - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
 - If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

- You have the right, in most cases, to obtain estimates in advance:
 - from out-of-network providers of what they will charge for their services; and
 - from your insurer of what it will pay for the services.

- You may obtain a current directory of preferred providers at the following website: www.bcbstx.com or by calling the Customer Service number on the back of your ID card for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

- If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than \$1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.