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# INTRODUCTION

## EXPLANATION

This Plan has been designed and selected by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses. Please read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Schedule of Specifications provided to your Employer by BCBSTX prevails.

The medical benefits available to you are determined by where you reside or work. If you reside or work in your Employer's selected Plan Service Area, you are eligible for In-Network and Out-of-Network Benefits under the Managed Health Care coverage. If you live or work outside of your Employer's Plan Service Area, you are eligible for Out-of-Area Benefits under the Traditional Out-of-Area coverage. This Benefit Booklet summarizes Plan benefits and provisions for the following:

- **MANAGED HEALTH CARE COVERAGE**  
Comprehensive medical care preferred provider benefits (*referred to as In-Network or Out-of-Network*) for Participants residing/working in the Plan Service Area
- **TRADITIONAL OUT-OF-AREA COVERAGE**  
Traditional benefit coverage (*referred to as Out-of-Area*) for Participants residing outside of the Plan Service Area

### MANAGED HEALTH CARE IN-NETWORK BENEFITS

If you live or work in the Network Plan Service Area,

- In-Network Benefits are available through Providers listed in your Network directory.
- Out-of-Network Benefits are available for Eligible Expenses incurred outside the Network of Providers; however, the Plan pays a reduced benefit and your health care costs are greater.

To receive In-Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care (**other than for emergencies**). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider Directory to make your selections. An updated directory will be available at least annually.

To receive In-Network Benefits for Mental Health Care, treatment of Serious Mental Illness or treatment of Chemical Dependency, all care must be precertified. Precertification is accessed by calling the Mental Health Helpline indicated in this Benefit Booklet and on your Identification Card.

Services and supplies for Mental Health Care, treatment of Serious Mental Illness or treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claims Administrator to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

If you choose a Network Provider, the Provider will bill the Claims Administrator not you for services provided. The Provider has agreed to accept as payment in full the least of...

- The billed charges,
- The Allowable Amount as determined by the Claims Administrator, or
- Other contractually determined payment amounts, and any Deductibles, Copayment Amounts and Co-Share Amounts you are responsible for paying.

You may be required to pay for limited or noncovered services. No claim forms are required.

### MANAGED HEALTH CARE OUT-OF-NETWORK BENEFITS

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available.

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

- Billed charges above the Claims Administrator's Allowable Amount,
- Copayment and Co-Share Amounts,
- Deductibles,
- Precertification, and
- Limited or noncovered services.

## INTRODUCTION

### TRADITIONAL OUT-OF-AREA BENEFITS

Out-of-Area Benefits are provided through a traditional indemnity arrangement for Participants residing outside of the Managed Health Care coverage Plan Service Area and, therefore, do not have access to Network Providers.

You may have to submit claims for the services provided. You will be responsible for...

- Billed charges above the Claims Administrator's Allowable Amount,
- Co-Share Amounts,
- Deductibles,
- Precertification, and
- Limited or noncovered services.

### CUSTOMER SERVICE HELPLINE

*The Customer Service Helpline can:*

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

You can reach the Customer Service Helpline Monday through Friday from 8:00 a.m. to 8:00 p.m., Central Time.

**Toll free: 1-800-521-2227**

### MENTAL HEALTH HELPLINE

Network Physicians, Professional Other Providers, Participants, or anyone else seeking treatment for Mental Health Care, Serious Mental Illness, or Chemical Dependency for Participants can call the Mental Health Helpline at any time, day or night.

**Toll free: 1-800-528-7264**

### MEDICAL PRECERTIFICATION HELPLINE

To satisfy all medical precertification requirements for Inpatient Hospital Admissions, Extended Care Expense, or Home Infusion Therapy, call the Medical Precertification Helpline, Monday C Friday, 7:30 a.m. - 8:00 p.m., Central Time.

**Dallas area: (972) 783-4475**  
**Toll free: 1-800-441-9188**

## WHO GETS BENEFITS

### ELIGIBILITY REQUIREMENTS FOR COVERAGE

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

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;

*Civilians - the effective date is the first of the month following the date of employment.*

*Fire and Police - the effective date is the first day of employment.*

2. Described in the **Dependent Enrollment Period** section for a new Dependent of an Employee already having coverage under the Plan.

#### **Employee Eligibility**

You are eligible for coverage under the Plan if you are an Employee. For participation in **Managed Health Care Coverage**, an Employee must also reside or work in the Plan Service Area. You may apply for coverage for yourself or for yourself and your family members on or before your Eligibility Date if you are:

1. A regular full-time Employees in Active Service who work a minimum of thirty (30) hours per week for the Employer; or
2. Retirees
  - Civilian Employees who are eligible for and retired under the Employer's Early Retirement Program and/or in accordance with other city policies; or
  - Police Officers who are eligible for and retired on or after April 1, 1984, under Texas Municipal Retirement System (TRMS); or
  - Fire Fighters who are eligible for and retired on or after April 1, 1984, under the Beaumont Fireman's Relief and Retirement Fund.

#### **Dependent Eligibility**

If you apply for coverage, you may include your Dependents. However, if you are married to another Employee, and you apply to cover your spouse as a Dependent, your spouse may not apply for coverage.

Only one of you may cover any Dependent children. A Dependent is described in **DEFINITIONS** in this Benefit Booklet.

### EFFECTIVE DATES OF COVERAGE

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

#### **Timely Applications**

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

If you apply for coverage for yourself or for yourself and your eligible Dependents, and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claims Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;
2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; and
3. Become eligible after the Plan Effective Date and if the application is received by the Claims Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective as provided in the Claims Administrative Document (see your Employer for this Effective Date information).

#### **Effective Dates & Delay of Benefits Provided**

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

#### **Effective Dates & Late Enrollee**

If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during

## WHO GETS BENEFITS

your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date.

### ***Loss of Other Health Insurance Coverage***

You shall become eligible to apply for coverage under the Plan for yourself and your Dependents, if each of the following conditions is met:

1. You were covered under a Health Benefit Plan, self-funded Health Benefit Plan or had other health insurance coverage at the time this coverage was previously offered; and
2. Declined coverage under the Plan in writing, on the basis of coverage under another Health Benefit Plan or self-funded Health Benefit Plan; and
3. Your prior Health Benefit Plan or self-funded Health Benefit Plan:
  - a. Under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, has been exhausted; or
  - b. Was terminated as a result of legal separation, divorce, death, termination of employment or a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
  - c. Was ended as a result of termination of the other plan's coverage; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self-funded Health Benefit Plan. Your coverage will become effective on your date of employment.

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

### ***Dependent Enrollment Period***

#### ***1. Special Enrollment Period Newborn Children (includes adopted children or children Involved in a suit for adoption)***

Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claims Administrator through the Plan Administrator within 31 days of birth and pay any required contributions within that 31-day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth (or date of adoption or date on which a suit for adoption is sought). If you notify the Claims

Administrator through the Plan Administrator after that 31-day period, your newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

#### ***2. Court Ordered Dependent Children***

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

#### ***3. Other Dependents***

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

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

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

### ***Other Employee Enrollment Period***

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child involved in a suit for adoption.

## WHO GETS BENEFITS

If the written application is received within 31 days of the birth, adoption, or date of the suit for adoption of a child, coverage for the child, you or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.

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

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

## CHANGES IN YOUR FAMILY

When the following events take place:

- You marry or divorce,
- A child is born, adopted, or involved in a suit for which the adoption of a child is sought,
- A child marries or reaches the age limit described below,
- A Participant in your family dies, or
- Your Employer receives a court order to provide health coverage for a Participant's child,

you should promptly notify the Claims Administrator through the Plan Administrator by filling out a form which has been furnished to your Employer. If you are adding a Dependent, you must submit an application and the coverage will become effective as described in ***Dependent Enrollment Period***.

The Schedule of Coverage indicates a "Dependent child age limit" selected by your Employer after which coverage under the Plan *automatically* terminates.

When a child marries or reaches the "Dependent child age limit," coverage under the Plan *automatically* terminates.

For additional information, see **Continuation Privilege** in this Benefit Booklet. **Notify your Employer promptly if any of these events occur.** If your Dependent's coverage is terminated, contributions paid will not be refunded for any period before the date of notification. Once we are notified, coverage terminates *automatically* and benefits for expenses incurred after termination are not available. If benefits are paid prior to notification to the Claims Administrator, refunds will be requested.

Coverage for your Dependent spouse *automatically* terminates upon divorce. In that event, please refer to **Continuation Privilege** in this Benefit Booklet.

Any additions in coverage under this provision will become effective on the date of the change.

## PARTICIPANT CHANGE FORM

Use this form to:

- Change your name,
- Add Dependents,
- Drop Dependents, or
- Cancel all or a portion of your coverages

You may obtain this form from your Employer or by calling the Claims Administrator's Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card.

If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form (see **Address Changes**, below).

After you have completed the Participant Change Form, return it to your Employer.

## ADDRESS CHANGES

Notify the Claims Administrator through the Plan Administrator of all changes in address for yourself and your Dependents. For Managed Health Care coverage, an address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area of the Network.

## HOW TO RECEIVE HEALTH CARE BENEFITS

### CONTRACTING/NON-CONTRACTING FACILITIES

*Applies to Out-of-Area, only*

BCBSTX has written contracts with many (but not all) Hospitals and Facility Other Providers. Those institutions are Contracting Facilities. An institution without a written contract with BCBSTX is a Non-Contracting Facility.

**Services or supplies furnished by a Non-Contracting Facility are not covered under the Out-of-Area portion of the Plan.**

However, in accident cases, the immediate, initial treatment necessary to stabilize the Participant furnished by any Hospital is subject to the benefits provided by the Plan.

### PARPLAN

*Applies to Out-of-Network and Out-of-Area, only*

When you consult a Physician or Professional Other Provider, you should inquire if he participates in the Claims Administrator's *ParPlan*... a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

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

You will be responsible for any applicable Deductibles, Co-Share Amounts, or services that are limited or not covered under the Plan.

If your Physician or Professional Other Provider does not participate in the *ParPlan*, it will be your responsibility to file your claims as described in **CLAIM FILING PROCEDURES** in this section, and you may be billed for services above the Claims Administrator's Allowable Amount determination.

### SPECIALTY CARE PROVIDERS

*Applies to Managed Health Care, only*

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

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

- If specialty care by an Out-of-Network Provider is needed, In-Network Benefits will still be available if a Network Physician notifies the Claims Administrator and the Claims Administrator acknowledges your visit to an Out-of-Network Provider prior to the visit; otherwise Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate, or
- If the services you require are not available from Network Providers, In-Network Benefits will be provided when you use Out-of-Network Providers.
- If you elect to see an Out-of-Network Provider, and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

### MEDICAL NECESSITY

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

### PRECERTIFICATION REQUIREMENTS

Precertification establishes in advance the Medical Necessity of certain care and services covered under this Plan. It ensures that the precertified care and services described below will not be denied on the basis of Medical Necessity. However, precertification does not guarantee payment of benefits. **Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.**

Precertification is simple. You, your Physician, Provider of services, or a family member calls one of the toll-free numbers listed on the back of your Identification Card. The call should be made between 7:30 a.m. and 8:00 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. In most cases precertification is

## HOW TO RECEIVE HEALTH CARE BENEFITS

made within minutes while we are on the telephone with your Provider's office.

### **The following types of services require precertification In-Network and Out-of-Network coverage:**

- All inpatient admissions,
- *Extended Care Expense*,
- Home Infusion Therapy,
- All treatment of Chemical Dependency,
- All treatment of Serious Mental Illness and Mental Health Care,
- If you transfer to another facility or to or from a specialty unit within the facility.

### **The following types of services require precertification Out-of-Area coverage:**

- All inpatient admissions,
- *Extended Care Expense*,
- Home Infusion Therapy,
- Inpatient treatment of Chemical Dependency,
- Inpatient treatment of Serious Mental Illness and Mental Health Care,
- If you transfer to another facility or to or from a Specialty unit within the facility.

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

**Out-of-Network:** If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. Failure to precertify services will be subject to guidelines described below. However, if care is not available from Network Providers as determined by the Claims Administrator, and the Claims Administrator acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

**Out-of-Area:** If you receive your care in a Contracting Facility and the services have been precertified, Out-of-Area Benefits will be available, subject to all Plan provisions.

### **Failure to Precertify**

**(In-Network, Out-of-Network and Out-of-Area)**

If precertification for each ***Inpatient Admission, Extended Care Expense, Home Infusion Therapy, and treatment of***

***Chemical Dependency, Serious Mental Illness, and Mental Health Care*** as described below is not obtained:

- The Claims Administrator will review the Medical Necessity of your treatment prior to the final benefit determination;
- If the Claims Administrator determines the treatment or service is not Medically Necessary, benefits will be denied; or
- In connection with a Hospital Admission, you may be responsible for a penalty, if indicated on your Schedule of Coverage. The penalty charge will be deducted from any benefit payment which may be due for the admission.

If a Hospital Admission or extension for any treatment or service described below is not precertified and it is determined that the admission or extension was not Medically Necessary, benefits will be reduced or denied.

### ***Inpatient Admissions***

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

When an inpatient admission is precertified, a length-of-stay is assigned. Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

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

If you require a longer stay than was first precertified, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

### ***Extended Care and Home Infusion Therapy***

Extended Care under the Plan includes Skilled Nursing Facility services, Home Health Care, and Hospice Care. Home Infusion Therapy is intravenous infusion or injection of fluids, nutrition, or medication done in the home setting.

## HOW TO RECEIVE HEALTH CARE BENEFITS

Precertification for Extended Care and Home Infusion Therapy must be obtained by having the agency or facility providing the services submit a treatment plan to the Claims Administrator on a Precertification Review Form. The Precertification Review Form must be completed:

- Before the start of Extended Care or Home Infusion Therapy;
- For periodic recertification of Extended Care or Home Infusion Therapy as required by the Claims Administrator; and
- When the treatment plan is altered.

The Claims Administrator will review the information submitted prior to the start of Extended Care or Home Infusion Therapy. The Claims Administrator will send a letter to you and the agency or facility confirming precertification or denying benefits.

If Extended Care or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the precertification telephone number previously indicated.

If Extended Care or Home Infusion Therapy is scheduled to occur within 72 hours, the Claims Administrator will notify the agency or facility by telephone.

If the Claims Administrator has given notification that benefits for the treatment plan requested are not available, claims will be denied.

**To satisfy all medical precertification requirements for Inpatient Hospital Admissions, Extended Care Expense, or Home Infusion Therapy, you must call:**  
Dallas area: (972) 783-4475  
Toll-free: 1-800-441-9188

*Chemical Dependency, Serious Mental Illness, Mental Health Care*

**In-Network, Out-of-Network, and Out-of-Area** All inpatient treatment of Chemical Dependency, Serious Mental Illness and Mental Health Care should be precertified.

### **In-Network and Out-of-Network**

All outpatient treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care should also be precertified. Your provider should contact the Claims Administrator for the names of Network Providers.

You or your Provider should contact the Mental Health Helpline for a referral to Network Providers who have

entered into a managed care arrangement with the Claims Administrator to furnish services and supplies for Mental Health Care, treatment of Serious Mental Illness, or treatment of Chemical Dependency. When your services have been precertified and are provided by the Network Provider, In-Network Benefits will be available.

**To satisfy precertification requirements for Mental Health Care, Serious Mental Illness, or Chemical Dependency, you must call the Mental Health Helpline at:**

**Dallas area: (972) 669-5201  
Toll-free: 1-800-528-7264**

## CASE MANAGEMENT

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

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

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

## CLAIM FILING PROCEDURES

### **Filing of Claims Required**

#### *Notice of Claim*

You must give written notice to the Claims Administrator within 20 days, or as soon as reasonably possible, after any Participant receives services for which benefits are provided under the Plan. Failure to give notice within this time will not invalidate or reduce any claim if you show that it was not reasonably possible to give notice and that notice was given as soon as it was reasonably possible.

#### *Claim Forms*

When the Claims Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other

## HOW TO RECEIVE HEALTH CARE BENEFITS

Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

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

### **Who Files Claims** *Medical Claims*

#### ***Network Providers***

When you receive treatment or care from a Network Provider or Professional Other Provider who contracts with the Claims Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

#### ***Out-of-Network or Out-of-Area Providers***

When you receive treatment or care from a health care Provider that does not participate in the Network or does not contract with the Claims Administrator, you may be required to file your own claim forms. However, some Providers will do this for you as further explained.

#### ***Provider-filed claims***

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

#### ***Participant-filed claims***

If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a form provided by the Plan. Your Employer should have a supply of claim forms. Remember to file each Participant's expenses separately because Deductibles, maximum benefits, and other provisions are applied to each Participant separately.

Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges and name of the Participant involved.

Instructions for completing the claim form are provided on the back of the form.

#### ***Where to Mail Completed Claim Forms***

Blue Cross and Blue Shield of Texas  
Claims Division  
P. O. Box 660044

Dallas, Texas 75266-0044

### **Who Receives Payment**

Benefit payments will be made directly to Network Providers or contracting Providers when they bill the Claims Administrator. Written agreements between the Claims Administrator and other Providers may require payment directly to them. However, if the benefit payments are for claims from Providers with no written agreement, the Claims Administrator may choose to pay either you or your Provider.

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

Except as provided in the section **ASSIGNMENT AND PAYMENT OF BENEFITS**, rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

### **When to Submit Claims**

All claims for benefits under the Plan must be properly submitted within 90 days of the date you receive the services or supplies. Claims not submitted and received by the Claims Administrator within 12 months after that date will not be considered for payment of benefits except in the absence of legal capacity.

### **Receipt of Claims by the Claims Administrator**

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Administrative Office of the Claims Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied, or the Claims Administrator may contact either you or the Provider for the additional information.

### **Review of Claim Determinations**

#### **Claim Determinations**

When the Claims Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claims Administrator will receive and review claims for benefits and will accurately process claims, consistent with administrative practices and procedures established in writing between the Claims Administrator and the Plan Administrator. The Claims Administrator will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If the Claims Administrator requires

## HOW TO RECEIVE HEALTH CARE BENEFITS

further information in order to process the claim, the Claims Administrator will request it within that 30-day period.

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

### ***If a Claim Is Denied or Not Paid in Full***

On occasion, the Claims Administrator may deny all or part of your claim. There are a number of reasons why this may happen. First read the *Explanation of Benefits* summary prepared by the Claims Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision. Include your full name, group and subscriber numbers with the request.

If the claim is denied in whole or in part, you will receive an *Explanation of Benefits* (EOB) summary or a letter of denial, from the Claims Administrator with the following information, if applicable:

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

### ***Right to Review Claim Determinations***

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for precertification, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

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

- Within 180 days after you receive notice of a denial or partial denial, write to the Claims Administrator. The Claims Administrator 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

- You may also designate a representative to act for you in the review procedure. 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.
- The Claims Administrator will honor telephone requests for information, however, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see documents relevant to the denial or partial denial and may submit written issues, comments, and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claims Administrator will give you a written decision within 60 days after it receives your request for review.
- If you have any questions about the claims processing procedures or the review procedure, write to the Claims Administrator or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

### ***Precertification Review Procedures***

If you or your Physician disagree with the determination of a precertification decision prior to or while receiving services, you may request a review of that decision by contacting the Claims Administrator.

In some instances, the resolution of the review process will not be completed until your inpatient admission or other service requiring precertification has occurred and/or your assigned length of stay or other service has elapsed. If you disagree with the Claims Administrator, you may request a review of that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

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

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

## HOW TO RECEIVE HEALTH CARE BENEFITS

precertification decision held by the Claims Administrator.

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

### *Interpretation of Plan Provisions*

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

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

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

### *Claim Dispute Resolution*

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

After exhaustion of all remedies offered by the Claims Administrator, you may exercise your right to appeal all adverse determinations with the Plan Administrator of your Health Benefit Plan. The Plan Administrator is the final interpreter of the Health Benefit Plan and may correct any defect, supply any omission or reconcile any inconsistency or ambiguity in such manner as it deems advisable. All final determinations and actions concerning the Health Benefit Plan administration and interpretation of benefits shall be made by the Plan Administrator. The Claims Administrator will cooperate in providing the Plan Administrator documents relevant to the claim or precertification decision but only upon receipt of a valid written authorization from you or your representative to release the relevant information.

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

## MEDICAL BENEFITS PROVIDED

### ELIGIBLE EXPENSES

This portion of the Plan provides benefits for three major categories of expenses:

- *Inpatient Hospital Expense*
- *Medical-Surgical Expense*
- *Extended Care Expense*

This section generally explains the medical benefits that are available under the Plan. Please remember to refer to **DEFINITIONS** for a description of terms such as *Inpatient Hospital Expense*, *Medical-Surgical Expense*, and *Extended Care Expense*.

Medical benefits under the Plan are described as follows:

- Managed Health Care In-Network Benefits
- Managed Health Care Out-of-Network Benefits
- Traditional Out-of-Area Benefits

Wherever Schedule of Coverage is mentioned, please refer to the Schedule(s) in this Benefit Booklet.

Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

### COPAYMENT AMOUNTS AND DEDUCTIBLES

The benefits of the Plan will be available after satisfaction of the applicable Copayment Amounts and Deductibles, if any, as shown on your Schedule of Coverage for In-Network, Out-of-Network, or Out-of-Area Benefits.

#### Copayment Amounts

*Applies to In-Network and Out-of-Network, only*

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Your Schedule of Coverage shows the “Copayment Amounts Required.”

A Copayment Amount will be required for most Physician office visits, except for services provided by an independent lab or radiologist requested by the Physician. If the services provided by your Physician require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required.

A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

The following services are not payable under this Copayment Amount provision but instead are considered *Medical-Surgical Expense*, subject to the Deductible, if applicable:

- surgery performed in the Physician’s office;
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an office visit;
- therapeutic injections;
- any services requiring precertification; or
- Certain Diagnostic Procedures.

#### Deductibles

1. The Deductibles are explained as follows:

- a. The Deductible, if any, shown under “Inpatient Hospital Expense Benefits” on your Schedule of Coverage will apply to **each** Hospital Admission of a Participant. This is also known as a per-admission Deductible.
- b. The individual Deductible, if any, shown under “Medical-Surgical Expense Benefits” on your Schedule of Coverage must be met by each Participant each Calendar Year. If shown on your Schedule of Coverage, this Deductible will also apply to *Extended Care Expense*.

2. The following are exceptions to the individual *Medical-Surgical Expense* Deductible described in paragraph 1b, above.

- a. If “Three-Month Deductible Carryover” is shown on your Schedule of Coverage, any *Medical-Surgical Expense* incurred during the last three months of a Calendar Year and applied toward satisfaction of the *Medical-Surgical Expense* Deductible for that Calendar Year may be applied toward satisfaction of that Deductible for the following Calendar Year.
- b. If you have several covered Dependents, all charges used to apply toward each Participant’s *Medical-Surgical Expense* Deductible will be applied toward the “Family Deductible” amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for

## MEDICAL BENEFITS PROVIDED

that Calendar Year. No Participant will contribute more than the individual Deductible amount to the family Deductible amount.

- c. *Medical-Surgical Expense* applied toward satisfying any Out-of-Network Deductible will apply toward satisfying any In-Network Deductible.
- d. ***Out-of-Area***: No deductible will be applied to any item of *Medical-Surgical Expense* incurred for Outpatient Surgery, Certain Outpatient Procedures, and/or focus procedures.

### CO-SHARE STOP-LOSS

Most of your Eligible Expense payment obligations, including Copayment Amounts, if any, are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss benefits.

1. Co-Share Amounts will **not** include:
  - Services, supplies, or charges limited or excluded by the Plan;
  - Expenses not covered because a benefit maximum has been reached;
  - Any Eligible Expenses paid by the Primary Carrier when the Plan is the Secondary Plan for purposes of coordination of benefits;
  - Deductibles;
  - Penalties applied for failure to precertify;
2. ***Managed Health Care***: There are separate Co-Share Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits. However, Eligible Expenses for Out-of-Network Benefits will apply to the Co-Share Amount for In-Network Benefits. Copayment Amounts for In-Network Benefits and Out-of-Network Benefits will continue to be required after the benefit percentages become 100%.

When the Co-Share Amount for the In-Network, Out-of-Network or Out-of-Area Benefit levels for a Participant in a Calendar Year equals the individual Co-Share Stop-Loss Amount shown on your Schedule of Coverage for that level, the benefit percentages automatically become 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant during the remainder of that Calendar Year for that level, except for the following as applied to Out-of-Area.

If “Mental Health Care Covered” is shown on your Schedule of Coverage:

- a. The benefit percentage for *Inpatient Hospital Expense* for Mental Health Care will remain at the percentage shown under “Mental Health Care covered” if that percentage is less than the percentage shown under “Inpatient Hospital Expense Benefit,” and
- b. The benefit percentage for *Medical-Surgical Expense* for Mental Health Care will remain at the percentage shown under “Mental Health Care covered” if that percentage is less than the percentage shown under “Medical-Surgical Expense Benefit.”

3. When the Co-Share Amounts for the In-Network, Out-of-Network or Out-of-Area Benefit levels for all Participants under your coverage equal the amount shown on your Schedule of Coverage for that level as “Family Co-Share Stop-Loss Amount” during a Calendar Year, the benefit percentages automatically become 100% for additional Eligible Expenses for all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Co-Share Amount to the family Co-Share Stop-Loss Amount.

### MAXIMUM LIFETIME BENEFITS

The total amount of benefits available to any one Participant under the Plan shall not exceed the “Maximum Lifetime Benefits” amount shown on your Schedule of Coverage.

This maximum lifetime benefits amount includes:

1. All payments made under any benefit provisions of the Plan including payments toward any other benefit maximums under the Plan; and
2. Any benefits provided to a Participant under a health care plan held by the Employer with the Claims Administrator immediately prior to the Participant’s Effective Date of coverage under this Plan.

### CHANGES IN BENEFITS

Changes to covered benefits will apply to all services provided to each Participant under the Plan.

Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider which begins before the change will be those benefits in effect on the day of admission.

## MEDICAL BENEFITS PROVIDED

### BENEFITS FOR INPATIENT HOSPITAL EXPENSE

Among those expenses normally included under *Inpatient Hospital Expense* as defined in this Benefit Booklet are intensive and coronary care units, operating room, lab and x-ray, and blood. Please note that if you are confined in a private room, only the Hospital's average semiprivate room rate is allowed as *Inpatient Hospital Expense*. Remember, each Hospital Admission requires precertification to receive In-Network Benefits.

***Out-of-Network:*** The benefit percentage of your total eligible *Inpatient Hospital Expense* in excess of any Deductible shown under "Inpatient Hospital Expense Benefits" on the Schedule of Coverage is the Plan's obligation. The remaining unpaid *Inpatient Hospital Expense* in excess of any Deductible is your obligation to pay.

This excess amount will be applied to the In-Network Co-Share Amounts.

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

***Out-of-Network:*** The benefit percentage of your total eligible *Inpatient Hospital Expense* in excess of any Deductible shown under "Inpatient Hospital Expense Benefits" on the Schedule of Coverage is the Plan's obligation. The remaining unpaid *Inpatient Hospital Expense* in excess of any Deductible is your obligation to pay. This excess amount will be applied to the In-Network and Out-of-Network Co-Share Amounts.

### BENEFITS FOR MEDICAL-SURGICAL EXPENSE

Included under *Medical-Surgical Expense* as defined in this Benefit Booklet are services such as Physicians and Professional Other Providers, speech and hearing services, diagnostic x-ray and laboratory examinations, Prosthetic Appliances, and Home Infusion Therapy. Remember that certain services require precertification, and any Copayment Amounts, Deductibles and Co-Share Amounts shown on your Schedule of Coverage will also apply.

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

The benefit percentages of your total eligible *Medical-Surgical Expense* shown under "Medical-Surgical Expense Benefits" on the Schedule of Coverage in excess of your Copayment Amounts, Co-Share Amounts and any Deductible shown are the Plan's obligation. The remaining unpaid *Medical-Surgical Expense* in excess of the Copayment Amount, Co-Share Amount and any Deductible is your obligation to pay.

To calculate your benefits, subtract any Copayment Amounts and Deductibles (if applicable) from your total eligible *Medical-Surgical Expense* and then multiply the difference by the benefit percentage shown on your Schedule of Coverage under "Medical-Surgical Expense Benefit." Most remaining unpaid *Medical-Surgical Expense* in excess of the Copayment Amount and Deductible is your Co-Share Amount.

### BENEFITS FOR EXTENDED CARE EXPENSE

When *Extended Care Expense* has been precertified, the Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expense Benefits," and
2. Up to the amount of the combined benefit maximums shown for each category of *Extended Care Expense* on your Schedule of Coverage.

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

***Out-of-Area:* Benefits are not available, unless services are rendered by a Contracting Facility and have been precertified and approved by the Claims Administrator.**

The benefit maximums will also include any benefits provided to a Participant for *Extended Care Expense* under a health care plan held by the Employer with the Claims Administrator immediately prior to the Participant's Effective Date of coverage under the Plan.

If shown on your Schedule of Coverage, the *Medical-Surgical Expense* Deductible will apply. Any unpaid *Extended Care Expense* in excess of the benefit

## MEDICAL BENEFITS PROVIDED

maximums shown on your Schedule of Coverage will not be applied to any Co-Share Amounts.

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

Services and supplies for *Extended Care Expense*:

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

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

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

3. For Home Hospice Care:
  - a. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
  - b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
  - c. Physical, speech, and respiratory therapy services by licensed therapists;

- d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

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

## OTHER BENEFIT PROVISIONS

Benefits available under this **OTHER BENEFIT PROVISIONS** section are generally determined on the same basis as for other *Inpatient Hospital Expense*, *Medical-Surgical Expense*, and *Extended Care Expense*, except to the extent described in the following subsections. Benefits will be determined as indicated on your Schedule(s) of Coverage(s). Remember that certain services require precertification and that any Copayment Amounts, Co-Share Amounts and Deductibles shown on your Schedule(s) of Coverage(s) will also apply.

### 1. *Benefits for Treatment of Complications of Pregnancy*

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

### 2. *Benefits for Maternity Care*

- a. Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for Maternity Care benefits only if "Dependent Children Eligible for Maternity Care" is shown on your Schedule of Coverage,
- b. Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan,
- c. The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:
  - 48 hours following an uncomplicated vaginal delivery; and
  - 96 hours following an uncomplicated delivery by caesarean section.

## MEDICAL BENEFITS PROVIDED

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for postdelivery care for the mother and newborn. The *Postdelivery Care* may be provided at the mother's home, a health care Provider's office, or a health care facility.

*Postdelivery Care* means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education,
- assistance and training in breast-feeding, bottle feeding, and
- the performance of any necessary and appropriate clinical tests.

*Inpatient Hospital Expense* incurred by the mother for delivery of a child will not include charges for routine well-baby nursery care of the newborn child during the mother's Hospital Admission for the delivery. These charges will be considered *Inpatient Hospital Expense* of the child and will be subject to the benefits provisions and benefit maximums as described elsewhere in this section. Benefits will also be subject to a per-admission Deductible if shown under "Inpatient Hospital Expense Benefits" on your Schedule of Coverage.

### 3. *Benefits for In Vitro Fertilization Services*

(Available unless "In Vitro Fertilization Services Not Covered" is shown on your Schedule of Coverage)

Benefits for *Medical-Surgical Expense* incurred for in vitro fertilization services will be the same as for Maternity Care provided **all** of the following requirements are met:

- a. The patient is a married Participant;
  - b. The fertilization or attempt at fertilization is made only with the sperm of the Participant's husband;
  - c. The Participant and her husband have a history of infertility of at least five continuous years duration or the infertility is associated with one or more of the following conditions:
    - Endometriosis;
    - Exposure in utero diethylstilbestrol (DES);
    - Blockage or surgical removal of one or both fallopian tubes; or
- Oligospermia.
- d. The Participant has been unable to obtain a successful pregnancy through any less costly

applicable infertility treatment which is covered under the Plan; and

- e. The in vitro fertilization procedures are performed in a facility licensed and approved to provide in vitro fertilization services under the appropriate state authority, if any.

No benefits for in vitro fertilization services are available if:

- Any condition contained in items (a) through (e) indicated above, is not complied with;
- The Employer has not applied for Maternity Care benefits;
- The Employer has rejected the offer of benefits for in vitro fertilization services; and
- The services or supplies are for *Inpatient Hospital Expense*.

### 4. *Benefits for Mental Health Care and Chemical Dependency Treatment*

If "Mental Health Care/Chemical Dependency Treatment Covered," is shown on your Schedule of Coverage, benefits for *Inpatient Hospital Expense* and *Medical-Surgical Expense* for Mental Health Care and for treatment of Chemical Dependency are available as indicated. If your Schedule of Coverage indicates "Serious Mental Illness Covered," refer to ***Benefits for Serious Mental Illness*** to determine benefits. **NOTE:** Refer to **PRECERTIFICATION REQUIREMENTS** to determine what services require precertification.

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 the series of Chemical Dependency treatments. (Mental Health Care after completion of a series of treatments will be considered Mental Health Care.)

Coverage for treatment of Chemical Dependency will be limited to a maximum of three separate series of treatment for each covered individual. The Plan may use state guidelines to administer benefits for treatment of Chemical Dependency.

Inpatient treatment of Chemical Dependency must be provided in a Substance Abuse Facility. Benefits for the medical management of acute life-threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **BENEFITS FOR INPATIENT HOSPITAL EXPENSE**.

## MEDICAL BENEFITS PROVIDED

Benefit percentages for *Inpatient Hospital Expense* and *Medical-Surgical Expense* will be as shown on your Schedule of Coverage. The same per-admission and Calendar Year Deductibles, if any, shown on your Schedule of Coverage will be applied to the treatment of Mental Health Care and Chemical Dependency.

*Inpatient Hospital Expense* for Mental Health Care and Chemical Dependency will be limited to the number of inpatient days per Calendar Year shown on your Schedule of Coverage.

Benefits for *Medical-Surgical Expense* incurred for Mental Health Care and Chemical Dependency Treatment will be limited to the number of inpatient Physician/Professional Other Provider visits.

Medically Necessary treatment of Chemical Dependency and/or Mental Health Care in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered *Inpatient Hospital Expense*. *Inpatient Hospital Expense* benefit percentages for this Plan, and the per-admission Deductible, if any, as shown on your Schedule of Coverage will apply. Each full day of treatment in such facility will be considered equal to one-half of one day of a regular Hospital Admission for Mental Health Care and Treatment of Chemical Dependency.

All inpatient benefits used, including Hospital days and Physician/Professional Other Provider visits, whether In-Network, Out-of-Network, or Out-of-Area apply to inpatient days or visits shown on the Schedule of Coverage under all level of benefits.

All outpatient Physician/Professional Other Provider and other outpatient visit benefits used, whether In-Network, Out-of-Network, or Out-of-Area apply to the In-Network and Out-of-Network or Out-of-Area outpatient visits shown on the Schedule of Coverage under all levels of benefits.

The benefits provided for Mental Health Care and Chemical Dependency will not exceed the maximum lifetime benefit amount shown on your Schedule of Coverage.

The lifetime maximum, if any, will also include any benefits provided to a Participant for Mental Health Care and Chemical Dependency under a health care plan held by the Employer with BCBSTX

immediately prior to the Participant's Effective Date of coverage under this Plan.

### 5. ***Benefits for Emergency Care and Treatment of Accidental Injury***

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

#### **Managed Health Care Benefits, only**

If reasonably possible, contact your Network Physician before going to the Hospital emergency room. He can help you determine if you need Emergency Care and recommend that care. If not reasonably possible to contact your Network Physician, go to the nearest emergency facility, whether or not the facility is in the Network. A Copayment Amount may be required if you go to a Hospital emergency room.

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

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for In-Network Benefits. After 48 hours, In-Network Benefits will be available only if you use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency and if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.

In-Network and Out-of-Network Benefits for Eligible Expenses will be determined on the same basis as for treatment of any other sickness. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room visit as indicated on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived. Precertification of the inpatient admission will be required.

Benefits for Eligible Expenses incurred for the continued treatment of an Accidental Injury sustained while covered under the Employer's health care plan

## MEDICAL BENEFITS PROVIDED

will be considered on the same basis as for treatment of any other sickness.

### ***Out-of-Area Benefits, only***

- a. Benefits for Eligible Expenses incurred for treatment of an Accidental Injury while covered under the Employer's health care plan will be considered on the same basis as for sickness **unless** your Schedule of Coverage indicates "Accidental Injury Benefit" or "Accidental Injury Supplement".
- b. If "Accidental Injury Benefit" or "Accidental Injury Supplement" is shown on your Schedule of Coverage, benefits for treatment of an Accidental Injury will be available as described below but only if:
  - (1) You are covered under the Plan on the date the Accidental Injury occurred; and
  - (2) The initial necessary medical care is provided by a Physician or Professional Other Provider within 30 days after the accident.

No *Medical-Surgical Expense* Deductible will be applied to expenses incurred for treatment of an Accidental Injury for the remainder of the Calendar Year in which the Accidental Injury occurred. However, any *Inpatient Hospital Expense* Deductible, if applicable, will be applied.

The Plan will provide benefits for Eligible Expenses incurred within the 90-day period following the occurrence of the Accidental Injury and as a result thereof, as follows:

If "Accidental Injury Benefit" is shown on your Schedule of Coverage, the applicable Eligible Expenses for treatment of the Accidental Injury will be covered in full up to the maximum benefit amount shown in your Schedule of Coverage for any one accident. Any remaining Eligible Expenses over and above this maximum benefit amount will be considered for benefits as described elsewhere in this Benefit Booklet.

If "Accidental Injury Supplement" is shown on your Schedule of Coverage, the applicable Eligible Expenses for treatment of the Accidental Injury will first be considered for benefits as described elsewhere in this booklet. Any remaining Eligible Expenses in excess of these benefits will be provided up to the

maximum benefit amount shown in your Schedule of Coverage for any one accident.

### 6. ***Benefits for Serious Mental Illness***

If "Serious Mental Illness Covered" is shown on your Schedule of Coverage, benefits for *Inpatient Hospital Expense* and *Medical-Surgical Expense* may be considered on the same basis as for treatment of any other sickness. Refer to your Schedule of Coverage to determine your particular benefits.

**NOTE:** Refer to **PRECERTIFICATION REQUIREMENTS** to determine what services require precertification.

### 7. ***Benefits for Preventive Care***

If "Preventive Care Benefit" is shown on your Schedule of Coverage, benefits are available for *Medical-Surgical Expense* incurred for:

- well-baby care;
- routine physical examinations;
- vision examination
- vision benefit (if indicated on your Schedule of Coverage);
- hearing examinations, except for benefits as provided under ***Benefits for Screening Test for Hearing Impairment***;

Benefits may also be available for immunizations for Participants age six and over. Benefits for childhood immunizations for children from birth to 6 years of age will be provided as described in ***Benefits for Childhood Immunizations***.

Benefits for preventive care services will be determined as indicated on your Schedule of Coverage for Physician office visits, diagnostic lab and x-rays.

Benefits are not available for *Inpatient Hospital Expense* or *Medical-Surgical Expense* for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

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

### 8. ***Benefits for Screening Test for Hearing Impairment***

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

- For a screening test for hearing loss from birth through the date the child is 30 days old; and

## MEDICAL BENEFITS PROVIDED

- Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months.

Any Deductible will not apply.

### 9. **Benefits for Childhood Immunizations**

Benefits for *Medical-Surgical Expense* incurred by a Dependent child for childhood immunizations from birth through the date the child turns six years of age will be determined at 100% of the Allowable Amount. The Deductible, Co-Share and any Copayment Amounts will not be applicable. Benefits are available for:

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

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

### 10. **Benefits for Mammography Screening**

If a Participant age 35 years of age or older incurs a *Medical-Surgical Expense* for a screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other *Medical-Surgical Expense* as shown on your Schedule of Coverage, except that benefits will not be available for more than one mammography screening each Calendar Year.

### 11. **Benefits for Cosmetic, Reconstructive, or Plastic Surgery**

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

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant while covered under the Employer's health care plan; or
- Treatment provided for reconstructive surgery following cancer surgery while the Participant

was covered under the Employer's health care plan; or

- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a Dependent child (other than a newborn child) under the age of 25 for the treatment or correction of a congenital defect other than conditions of the breast.
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.
- Reconstructive surgery performed on a Dependent child under the age of 25 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure.

### 12. **Benefits for Dental Services**

If a Participant incurs Eligible Expenses for dental services, benefits will be the same as for treatment of any other sickness as shown on the Schedule of Coverage.

Benefits are provided only for:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, unrestored natural teeth and supporting tissues occurring while the Participant was covered under this Plan and limited to such services and supplies provided:

- for 24 months from the date of the accident;  
or
- to the termination date of this Plan,

whichever occurs first; except that an injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **Medical Limitations and Exclusions** section of this Benefit Booklet, for which a Participant incurs *Inpatient Hospital Expense* for a Medically Necessary Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expense**.

## MEDICAL BENEFITS PROVIDED

### 13. *Benefits for Organ and Tissue Transplants*

When a transplant procedure is needed, have your Physician contact the Claims Administrator's transplant coordinator in the Case Management department. The transplant coordinator may be able to arrange for benefits not otherwise provided under this Plan for transplants received in *selected* transplant Hospitals. *Selected* transplant Hospitals are noted for their success rate with particular transplant procedures.

Services provided before admission to and after discharge from a *selected* transplant Hospital will be subject to the benefits described in this Plan. Please be advised you can only access arrangements made with *selected* transplant Hospitals through our transplant coordinator within the Case Management program. However, Participants choosing to use *selected* transplant hospitals for transplant care do so at their option.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory, chemotherapy, radiation therapy, and complications arising from such transplant.

a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant (donor and/or recipient) by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if:

- (1) The transplant procedure is not Experimental/Investigational in nature;
- (2) Donated human organs or tissue are used;
- (3) The recipient is a Participant under the Plan (benefits are also available to the donor who is a Participant under the Plan);
- (4) The transplant procedure is precertified as provided in paragraph e below;
- (5) The Participant meets all of the criteria established by the Claims Administrator; and
- (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is for the following:

- Liver
- Heart

- Heart - Lung (heart and one lung or heart and both lungs)
- Kidney
- Cornea
- Lung
- Bone Marrow

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

- (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
- (2) Removal of organs or tissues from deceased donors; and
- (3) Transportation and storage of donated organs or tissues.

d. No benefits are available for a Participant for the following services or supplies:

- (1) Living and/or travel expenses of the live donor or recipient;
- (2) Donor search and acceptability testing of potential living donors;
- (3) Expenses related to maintenance of life for purposes of organ or tissue donation; and
- (4) Purchase of the organ or tissue.

e. Precertification is required for any organ or tissue transplant and is the process by which the Medical Necessity of the transplant and the length of stay of the admission is approved or denied. Precertification does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the precertified length of stay will not be denied on the basis of Medical Necessity.

At the time of precertification, the Claims Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claims Administrator determines that an extension is Medically Necessary.

f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such procedure) which the Claims Administrator considers to be Experimental/Investigational.

### 14. *Benefits for Detection and Prevention of Osteoporosis*

## MEDICAL BENEFITS PROVIDED

If a Participant is a *qualified individual*, benefits will be determined on the same basis as any other sickness for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

*Qualified Individual* means:

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

### 15. *Benefits for Certain Tests for Detection of Prostate Cancer*

If a male Participant incurs *Medical-Surgical Expense* for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided only for a:

- physical examination for the detection of prostate cancer; and
- prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:
  - 50 years of age and asymptomatic; or
  - 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

### 16. *Benefits for Speech and Hearing Services*

Services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function, as shown on the Schedule of Coverage.

Benefits are not available for hearing aids, as they are not covered under this Plan.

## MEDICAL LIMITATIONS AND EXCLUSIONS

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

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

This exclusion does not apply to the following, as described in **OTHER BENEFIT PROVISIONS**:

  - a. preventive care, if shown on your Schedule of Coverage,
  - b. mammography screening,
  - c. certain tests for the detection of prostate cancer,
  - d. well-baby check ups,
  - e. detection and prevention of osteoporosis,
  - f. childhood immunizations as provided in this Plan,
  - g. screening tests for hearing impairment, or
  - h. tests for detection of colorectal cancer.
15. Any services or supplies (except for Medically Necessary surgical and/or diagnostic procedures) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles and nerves that are non-surgical (*dental restorations, orthodontics, or*

## MEDICAL LIMITATIONS AND EXCLUSIONS

*physical therapy*), non-diagnostic, or supplies (*oral appliances, oral splints, oral orthotics, devices, or prosthetics*).

16. Any services or supplies provided for orthognathic surgery after the Participant's 19th birthday. (except orthognathic surgery for treatment of temporomandibular joint disorders and conditions of temporomandibular joint disorders as described in item 15 above, are covered) Orthognathic surgery includes, but is not limited to, correction of congenital, developmental or acquired maxillofacial skeletal deformities of the mandible and maxilla.
17. Any items of *Medical-Surgical Expense* incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in **OTHER BENEFIT PROVISIONS**.
18. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in **OTHER BENEFIT PROVISIONS**.
19. Any services or supplies provided for:
  - Treatment of myopia and other errors of refraction, including refractive surgery; or
  - Orthoptics or visual training; or
  - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
  - Examinations for the prescription or fitting of eyeglasses or contact lenses, except as may be provided under **Benefits for Preventive Care**.
  - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as shown on the Schedule of Coverage.
20. Except as specifically included as an Eligible Expense, any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.
21. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and oppositional disorders.
22. 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.
23. Travel, whether or not recommended by a Physician or Professional Other Provider, except for local ground ambulance service or air ambulance service otherwise covered under the Plan.
24. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
25. Any services or supplies provided primarily for:
  - Environmental Sensitivity;
  - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
  - Inpatient allergy testing or treatment.
26. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
27. Any services or supplies provided for, in preparation for, or in conjunction with:
  - Sterilization reversal (male or female);
  - Transsexual surgery;
  - Sexual dysfunction;
  - In vitro fertilization but only if your Schedule of Coverage indicates "In Vitro Fertilization Services Not Covered;"
  - Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer, and tubal embryo transfer.
28. Any services or supplies for routine foot care, such as:
  - The cutting or removal of corns or callouses, the trimming of nails (including mycotic nails) and other hygienic and preventive care maintenance in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory or bedfast patients;
  - Any services performed in the absence of localized illness, injury, or symptoms involving the foot;
  - Any treatment of a fungal (mycotic) infection of the toenail in the absence of:

## MEDICAL LIMITATIONS AND EXCLUSIONS

- Clinical evidence of mycosis of the toenail;
  - Compelling medical evidence that documents the patient either:
    - ? Has a marked limitation of ambulation requiring active treatment of the foot; or
    - ? In the case of a nonambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment; and
- Excision of a nail without using an injectable or general anesthetic.
29. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations; or any Retin-A or pharmacologically similar topical drugs.
30. Any smoking cessation prescription drug products, including, but not limited to, nicotine gum and nicotine patches.
31. Any services or supplies provided for the following treatment modalities:
- acupuncture;
  - video fluoroscopy;
  - intersegmental traction;
  - surface EMGs;
  - manipulation under anesthesia; and
  - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
32. Any benefits in excess of any specified maximums.
33. *As applied to **In-Network Benefits***: Any services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with the Claims Administrator will be provided at the Out-of-Network benefit level.
34. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

## DEFINITIONS

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

**Accidental Injury** means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider within 30 days after the occurrence.

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

1. ***For Hospitals and Facility Other Providers, Physicians and Professional Other Providers Contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield plan*** - The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts or other payment methodologies.

2. a. ***For Managed Health Care coverage For Hospitals and Facility Other Providers not contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield plan outside of Texas*** - The Allowable Amount will be the amount the Claims Administrator would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate, the Allowable Amount will be the lesser of billed charge or a per diem established by the Claims Administrator.

b. ***For Traditional Out-of-Area coverage For Hospitals and Facility Other Providers not contracting with the Claims Administrator***: No payment will be made by the Claims Administrator.

3. ***For procedures, services, or supplies provided in Texas by Physicians and Professional Other Providers not contracting with the Claims Administrator***: Allowable Amount will be the lesser of the billed charge or the amount the Claims Administrator would have considered for payment for the same covered procedure, service, or supply if

performed or provided by a Physician or Professional Other Provider with similar experience and/or skill.

If the Claims Administrator does not have sufficient data to calculate the Allowable Amount for a particular procedure, service, or supply, the Claims Administrator will determine an Allowable Amount based on the complexity of the procedure, service, or supply and any unusual circumstances or medical complications specifically brought to its attention, which require additional experience, skill, and/or time.

4. ***For procedures, services, or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with BCBSTX or any other Blue Cross and Blue Shield Plan*** - The Claims Administrator will establish an Allowable Amount using Texas regional or state allowable amounts applicable to procedures, services, or supplies of Physicians or Professional Other Providers with similar skills and experience.

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

6. ***For drugs administered by a Home Infusion Therapy Provider*** - The Allowable Amount will be the lesser of: (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark-down from the AWP established by the Claims Administrator and updated on a periodic basis.

7. ***For procedures, services or supplies provided to Medicare recipients***: The Allowable Amount will not exceed Medicare's limiting charge.

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

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

**Certain Diagnostic Procedures** means:

Bone Scan  
Cardiac Stress Test  
CT Scan (with or without contrast)

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MRI (Magnetic Resonance Imaging)  
Myelogram  
PET Scan (Positron Emission Tomography)  
Ultrasound

*This list is not inclusive and may be modified from time to time.*

**Certain Outpatient Procedures** means, including but not limited to, the following:

Adenoidectomy with Tonsillectomy  
Bone Scan  
Bunionectomy  
Cardiac Stress Test  
Carpal Tunnel Release  
CT Scan (with or without contrast)  
Ectropion Repair  
Endoscopic Procedures  
Entropion Repair  
Insertion of cardiac pacemaker  
Mastectomy, Partial  
MRI (Magnetic Resonance Imaging)  
Myelogram  
PET Scan (Positron Emission Tomography)  
Tonsillectomy  
Ultrasound

*This listing is not inclusive and may be periodically modified.*

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

**Chiropractic Services** means any services or supplies provided by or under the direction of a Doctor of Chiropractic.

**Claims Administrator** means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

*Claims Administrator* may also mean any successor named by the Plan Administrator.

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

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);

2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method; or
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen);
5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

**Complications of Pregnancy** means:

- Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as 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, eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
- Termination of pregnancy by nonelective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

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

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

**Co-Share Amount** means the dollar amount of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan. Refer to **CO-SHARE STOP-LOSS IN MEDICAL BENEFITS**

## DEFINITIONS

**PROVIDED** of this Benefit Booklet for additional information.

**Cosmetic, Reconstructive, or Plastic Surgery** means surgery that:

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

**Covered Drug** means any Legend Drug or injectable insulin, including disposable syringes and needles needed for self-administration:

1. Which is Medically Necessary and ordered by a Provider naming a Participant as the recipient;
2. For which a written or verbal Prescription Order is prepared by a Provider;
3. For which a separate charge is customarily made;
4. Which is not entirely consumed at the time and place that the Prescription Order is written;
5. Which is used for the purpose for which U.S. Food and Drug Administration (FDA) approval has been given; and
6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility.

**Covered Oral Surgery** means maxillofacial surgical procedures limited to:

1. Excision of nondental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and nondental related procedures of the accessory sinuses; and
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an

accident, a trauma, a congenital defect, a developmental defect or a pathology.

**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 Mental Health Care and treatment of Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

**Custodial Care** means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. *Custodial Care* is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

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

**Dependent** means:

- Your spouse; or
- Any unmarried *child* who is either:
  - Under the limiting age selected by your Employer as shown on the Schedule of Coverage; or
  - A child of any age who is medically certified as disabled and dependent on the parent for support.

*Child* means:

- Your natural child; or
- Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or
- Your stepchild whose primary residence is your household; or
- A child for whom a Participant has received a court order requiring that Participant to have financial responsibility for providing health coverage; or

A child:

- ? whose primary residence is your household; and
- ? to whom you are legal guardian or related by blood or marriage; and

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? who is dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

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

**Diabetic Equipment and Supplies** means those items of Medical-Surgical Expense associated with the treatment of diabetes. Such items, when obtained for a *Qualified Participant*, shall include the following:

- **Diabetic Equipment:** Blood glucose monitors (including monitors for the blind), insulin pumps and necessary accessories, insulin infusion devices, and podiatric appliances for the prevention of complications associated with diabetes.
- **Diabetic Supplies:** Test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and non prescriptive oral agents for controlling blood sugar levels and glucagon emergency kits.

Injectable insulin shall be limited to no more than four 10cc vials on any occasion when the insulin is dispensed. The quantity of disposable syringes and needles covered for self-administered injections shall be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles on any occasion dispensed.

A *Qualified Participant* means an individual eligible for coverage under the Plan who has been diagnosed with: (i) insulin dependent or noninsulin dependent diabetes, (ii) elevated blood glucose levels induced by pregnancy, or (iii) another medical condition associated with elevated blood glucose levels.

**Diabetic Management Services** means *Medical-Surgical Expense* provided for the nutritional, educational and psychosocial treatment of the diabetic patient. Such management is limited to the following services when rendered by or under the direction of a Physician:

Initial and follow-up instruction concerning:

1. The physical cause and process of diabetes;

2. Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
3. Prevention and treatment of special health problems for the diabetic patient;
4. Adjustment to lifestyle modifications;
5. Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

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

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

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

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

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

**Eligible Expenses** means either *Inpatient Hospital Expense*, *Medical-Surgical Expense*, or *Extended Care Expense*, as specified in this Benefit Booklet.

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

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions;

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3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Employee** means a person who:

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

If the Employer has elected to cover retired Employees, the term *Employee* shall also include those persons, who are considered retired Employees under the Employer's established procedures whereby individual selection by the Employer or the Employee to be included in the retired Employee classification is precluded.

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

**Employer** means, in addition to the person, firm or institution named on the cover of this Benefit Booklet, one or more subsidiaries or affiliates, if any, listed in the Plan.

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

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special nonorganic, nonrepetitive diet techniques.

**Experimental/Investigational** means the use of any treatment, procedure, facility, equipment, drug, device, or

supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. *Approval* by a Federal agency means that the treatment, procedure, facility, equipment, drug 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:

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

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

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

**Extended Care Expense** means the services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in **BENEFITS FOR EXTENDED CARE EXPENSE**.

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

## DEFINITIONS

### *The term does not include:*

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

18. Other coverage that is:

- similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
- specified in federal regulations;

19. Coverage for onsite medical clinics; or

20. Coverage that provides other limited benefits specified by federal regulations.

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

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

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

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

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

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

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

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

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

**Hospital** means a short-term acute care facility which:

1. Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organization or is certified as a hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;
3. Has organized departments of medicine and major surgery and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
5. Has in effect a Hospital Utilization Review Plan; and
6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

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

a bed patient in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Plan.

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

**Identification Card** means the card issued to the Employee by the Claims Administrator of the Plan indicating pertinent information applicable to his coverage, including appropriate Copayment Amounts.

**Imaging Center** means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.

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

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

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

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

An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made. *Inpatient Hospital Expense* shall include:

- Room accommodation charges. *If the Participant is in a private room, the amount of the room charge in*

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*excess of the Hospital's average semiprivate room charge is not an Eligible Expense.*

- All other usual Hospital services which are Medically Necessary and consistent with the condition of the Participant. *Personal items are not an Eligible Expense.*

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be *Inpatient Hospital Expense*.

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

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

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

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

**Medical-Surgical Expense** means the Allowable Amount incurred for the items of service or supply listed below for the care of a Participant, provided such items are:

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

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

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

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

*Medical-Surgical Expense* shall include:

1. Services of Physicians or Professional Other Providers, and in the case of a Licensed Dietitian, Licensed Master Social Worker-Advanced Clinical Practitioner, Licensed Professional Counselor, or Licensed Marriage and Family Therapist, a professional recommendation has been obtained from a Physician.
2. Services of a certified registered nurse-anesthetist.
3. Physical Medicine Services
4. Chiropractic Services, as shown on your Schedule of Coverage, under *Medical-Surgical* Benefit. All payments made by the Plan, whether under the In-Network, Out-of-Network, or Out-of-Area Benefit level, will apply toward the benefit maximum under all levels of benefits. The Calendar Year maximum under all levels of benefits will also include any benefits provided to a Participant for Chiropractic Services under a health care plan held by the Employer with the Claims Administrator immediately prior to the Participant's Effective Date of coverage under this Plan.
5. Diagnostic x-ray and laboratory procedures.
6. Radiation therapy.
7. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan.

***The term "durable medical equipment" shall not include:***

- Equipment primarily designed for alleviation of pain or provision of patient comfort; or
- Home air fluidized bed therapy.

Examples of noncovered equipment include, but are not limited to, air conditioners, air purifiers,

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humidifiers, physical fitness equipment, and whirlpool bath equipment.

8. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.
9. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
10. Oxygen and its administration, provided the oxygen is actually used.
11. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
12. Prosthetic Appliances excluding all replacements of such devices other than those necessitated by growth to maturity of the Participant.
13. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.  
  
Non-Covered items include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a nonhospital 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. However, this does not apply to podiatric appliances when provided as Diabetic Equipment.
14. Services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function.
15. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Substance Abuse Facility.
16. Diabetic Management Services.

17. Diabetic Equipment and Supplies, including but not limited to, Prescription Orders for insulin, insulin analogs, prescriptive and nonprescriptive oral agents for controlling blood sugar levels.

*However*, if "Prescription Drug Program" is indicated on your Schedule of Coverage, insulin, insulin analogs (along with syringes necessary for self-administration), prescriptive and non-prescriptive oral agents will be covered under the Prescription Drug Program.

18. Certain Outpatient Procedures.

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

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

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

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

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the *Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association*, as revised, or any

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other diagnostic coding system as used by the Claims Administrator, whether or not the cause of the disease, disorder or condition is physical, chemical, or mental in nature or origin;

2. The diagnosis or treatment of any symptom, condition, disease or disorder by a Physician or Professional Other Provider (or by any person working under the direction or supervision of a Physician or Professional Other Provider) when the Eligible Expense is:
  - a. Individual, group, family or conjoint psychotherapy,
  - b. Counseling,
  - c. Psychoanalysis,
  - d. Psychological testing and assessment,
  - e. The administration or monitoring of psychotropic drugs, or
  - f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

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

**Network Provider** means a Hospital, Physician, or Other Provider who has entered into an agreement with BCBSTX to participate as a managed care Provider.

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

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

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

1. **Facility Other Provider** is an institution or entity, only as listed:
  - 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
  - Substance Abuse Facility
  - Therapeutic Center
2. **Professional Other Provider** is a person or practitioner, when acting within the scope of his 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 Counselors
  - Licensed Dietitian
  - Licensed Hearing Instrument Fitter and Dispenser
  - Licensed Marriage and Family Therapist
  - Licensed Master Social Worker-Advanced Clinical Practitioner
  - Licensed Occupational Therapist
  - Licensed Physical Therapist
  - Licensed Professional Counselor
  - Licensed Speech-Language Pathologist
  - Physician Assistant
  - Psychological Associates who work under the supervision of a Doctor in Psychology

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

**Out-of-Area Benefits** means the benefits available under the Plan for services and supplies that are provided by an Out-of-Network Provider without a referral.

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

**Out-of-Network Provider** means a Hospital, Physician, or Other Provider, who has not entered into an agreement with BCBSTX as a managed care Provider.

**Participant** means an Employee, Dependent, or a retired Employee whose coverage has become effective under this Plan.

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

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

**Plan Administrator** means the named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

**Plan Anniversary Date** means the day, month, and year of the 12-month period following the Plan Effective Date and each 12-month period thereafter.

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

**Plan Month** means each succeeding monthly period, beginning on the Plan Effective Date.

**Plan Service Area** means the geographical area designated by the Employer which determines eligibility for In-Network and Out-of-Network benefits.

**Proof of Loss** means written evidence of a claim including:

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

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

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

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

**Psychiatric Day Treatment Facility** means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organization as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and treatment of Serious Mental Illness services to Participants 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 to be in lieu of hospitalization.

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

**Residential Treatment Center for Children and Adolescents** means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organization or the American Association of Psychiatric Services for Children as a residential treatment center for the provision

## DEFINITIONS

of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

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

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

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

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

**Specialty Care Provider** means a Physician or Professional Other Provider who has entered into an agreement with BCBSTX to participate as a managed care Provider of specialty services.

**Substance Abuse Facility** means an institution located in the State of Texas which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations; or

3. Licensed, certified, or approved as a Chemical Dependency treatment program or center by any agency of the State of Texas having legal authority to so license, certify, or approve.

Any Substance Abuse Facility located outside the State of Texas shall be licensed, certified, or approved as a Chemical Dependency treatment center by the appropriate agency of the state in which it is located and be accredited as such an institution by the Joint Commission on Accreditation of Healthcare Organizations.

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

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

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

## GENERAL INFORMATION

### PARTICIPANT/PROVIDER RELATIONSHIP

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

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

### ASSIGNMENT AND PAYMENT OF BENEFITS

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

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

### SUBROGATION

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

For the purposes of this provision, *subrogation* means the substitution of one person or entity (the Plan) in the place of another (you or your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

#### ***Right of Reimbursement***

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Plan will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits under this Plan, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement, or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

#### ***Right to Recovery by Subrogation or Reimbursement***

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

### REFUND OF BENEFIT PAYMENTS

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

## GENERAL INFORMATION

### COORDINATION OF BENEFITS

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

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

#### Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:

- group or blanket insurance;
- franchise insurance that terminates upon cessation of employment;
- group hospital or medical service plans and other group prepayment coverage;
- any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
- governmental plans, or coverage required or provided by law.

*Plan does not include:*

- any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
- a policy of health insurance that is individually underwritten and individually issued;
- school accident type coverage; or

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

2. **This Plan** means the part of this Contract that provides benefits for health care expenses.
3. **Primary Plan/Secondary Plan:** The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits

are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

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

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.
5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
6. **We or Us** means the Claims Administrator, (BCBSTX).

#### Order of Benefit Determination Rules

##### 1. General Information

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

##### 2. Rules

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

- a. **Non-Dependent/Dependent:** The benefits of the Plan which covers the Participant as an Employee, member, or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule

## GENERAL INFORMATION

established by Title XVIII of the Social Security Act and implementing regulations, Medicare is

- secondary to the Plan covering the Participant as a Dependent and
- primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee),

then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

- b. ***Dependent Child/Parents Not Separated or Divorced:*** Except as stated in paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

- The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
- If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

- c. ***Dependent Child/Parents Separated or Divorced:*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

- First, the Plan of the parent with custody of the child;
- Then, the Plan of the spouse of the parent with custody, if applicable;
- Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those

terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan.

This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. ***Joint Custody:*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in paragraph b.

- e. ***Active/Inactive Employee:*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this paragraph e does not apply.

- f. ***Continuation Coverage:*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

- First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);
- Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this paragraph f does not apply.

- g. ***Longer/Shorter Length of Coverage:*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member, or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

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### Effect on the Benefits of This Plan

#### 1. When This Section Applies

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

#### 2. Reduction in This Plan's Benefits

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

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

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

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

### Right to Receive and Release Needed Information

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

### Facility of Payment

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

### Right to Recovery

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

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. Any other person or organization.

## MEDICARE

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

## TERMINATION OF COVERAGE

The Claims Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claims Administrator will not always know of the events causing termination until after the events have occurred.

### Termination of Individual Coverage

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

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. Your employment terminates; or
3. The Plan is amended to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

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

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

## GENERAL INFORMATION

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

*Disabled* means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claims Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a disabled Dependent beyond the limiting age, the Claims Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

### **Termination of the Group**

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan. However, see **CONTINUATION PRIVILEGE**, below.

## CONTINUATION PRIVILEGE

The following events **may** provide an option to continue group coverage:

1. For your Dependents:
  - Your death or divorce; or
  - Your child's marriage or reaching the "Dependent child age limit".
2. For you and your Dependents:
  - The termination of your status as an Employee (except for reason of gross misconduct) or retirement;
  - If you are covered as a retired Employee, the filing of a Title XI bankruptcy proceeding by the group.

If such an event occurs, you or your Dependents should immediately contact your Employer to determine your rights. Also, refer to the *Important Notice to Employees and Dependents of Continuation Option (COBRA)* at the end of this Benefit Booklet.

If the occurrence of the event requires coverage to terminate and if there is a right to continue the group coverage, the election to do so must be made within 60 days. You or your Dependents may be required to pay your own contribution rates. Any continued coverage will be identical to that of similarly situated members of the group, including any changes (see your Schedule of Coverage). Hence, changes in the group contribution rates or benefits will change the contribution rates or benefits for any continued coverage.

The continued coverage automatically terminates after a period of time (never to exceed three years) but will be terminated earlier upon the occurrence of certain circumstances. These circumstances include, but are not limited to, nonpayment of contributions and coverage under any other group coverage which does not contain a limitation with respect to a preexisting condition of the Participant (even if such coverage is less valuable than your current health plan). Your Employer will give you more detailed information upon your request.

## INFORMATION CONCERNING EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

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

1. The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
2. The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information that the Claims Administrator has that will aid the Plan Administrator in making its annual reports.
3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions described in this Benefit Booklet. Claim filing and claim review procedures are found in the **HOW TO RECEIVE HEALTH CARE BENEFITS** section of this Benefit Booklet.
4. BCBSTX, as the Claims Administrator, is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.

## **GENERAL INFORMATION**

5. This Benefit Booklet is not a Summary Plan Description.
6. The Plan Administrator has given the Claims Administrator the initial authority to make certain benefit determinations in accordance with the benefits and procedures detailed in the Health Benefit Plan. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan's provisions and determining questions of eligibility and benefits. Any decision made by the Plan Administrator shall be final and conclusive.

### **AMENDMENTS**

The Plan may be amended or changed at any time by the Plan Administrator with prior written notice to the Claims Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

### **CLAIMS LIABILITY**

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

### **DISCLOSURE AUTHORIZATION**

A physical examination will not be required in connection with your application for coverage under the Plan. It will be necessary, if you file a claim for benefits, that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claims Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your covered Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

# NOTICES



## **Important Notice to Employees and Dependents of Continuation Option**

*(If you are married, both you and your spouse should take the time to read this notice carefully)*

The Consolidated Omnibus Budget Reconciliation Act (COBRA) passed by the 99th Congress provides that when Participants (Employees and Dependents) lose their eligibility for group health coverage because of any of the events listed below, they may elect to continue group health coverage. The continued coverage can remain in effect for a maximum period of either 18, 29 or 36 months depending on the reason that eligibility terminated.

### **Events qualifying for 18-month continuation are loss of eligibility as a result of:**

1. Reduction of Employee work hours; or
2. Employee retirement or termination (voluntary or involuntary), except for discharge for gross misconduct.  
Note: The 18 months can be extended to up to 29 months when any Participant is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA coverage and notice of such determination is provided both within 60 days of the determination and prior to termination of continuation coverage.

### **Events qualifying for 36-month continuation for Dependents are loss of eligibility as a result of:**

1. Death of the Employee;
2. Divorce or legal separation of the Employee;
3. Medicare eligible Employee (Employee becomes eligible for Medicare, leaving Dependents without group health coverage); or
4. Children who lose coverage due to eligibility provisions (for example: limiting age, marriage).

### **Who is eligible for the continuation option?**

Participants (Employees and Dependents) who are covered by the group health plan at the time of the qualifying event are qualified beneficiaries and are eligible to continue coverage. Each may make an independent election. A child born or adopted by the Employee during COBRA continuation is eligible to be a qualified beneficiary upon timely application.

### **How do the Participants apply?**

1. If a qualifying event is either: (a) the divorce of an Employee; or (b) a child becoming ineligible for coverage, the eligible Participants must notify the Employer in writing. Then, the Employer will give written notice to the Participants of the continuation option. If the qualifying event is the Employee's death, Medicare eligibility, or termination of employment (or reduction of hours), the Employer will give written notice to the Participants of the continuation option.
2. The eligible Participants have 60 days to give written notice to the Employer of their desire to continue coverage. The election must specify names of covered individuals and the reason for and date of the qualifying event.
3. A Participants' coverage shall terminate upon the occurrence of any of the following:
  - a. The maximum time period expires;
  - b. A continued Participant obtains coverage after the date of election under any other group health plan (as an Employee or otherwise) which does not contain an applicable exclusion for any preexisting condition of the Participant;
  - c. A continued Participant becomes covered by any Medicare benefits after the date of election;
  - d. The Employer no longer provides group health coverage for Employees; or
  - e. The required payment to continue coverage is not made on a timely basis.

A continued Participant's coverage may also be terminated for fraud or intentional misrepresentation of material fact to the same extent the coverage for a similarly situated non-continued Participant could be terminated.

Benefits for a continued Participant will be the same as those for active Employees. Rates will be based upon the rates for active Employees. If the Employer changes benefits or rates, the continued Participants will receive the new benefits and a new rate.

A service fee of 2% of the premium paid by active Participants is added to the premium and is payable by the continued Participant. An extra premium of 50% may be added for Participants who extend coverage from 18 to 29 months. You are responsible for premium payment.

Contact your Employer if you have any questions about COBRA.

**If continuation coverage is not elected, your group coverage will end.  
Note: COBRA is not applicable to certain small groups and to churches.**

## Notice to Blue Cross and Blue Shield of Texas Subscriber/Policyholder

### **BlueCard Program Savings**

Your Blue Cross and Blue Shield membership card - The BlueCard - gives you access to health care throughout the United States. Through the BlueCard Program, your membership card indicates to any participating hospital or physician which Blue Cross and/or Blue Shield Plan is yours. By using this BlueCard, you can help keep your costs down when you need health care away from home.

When you obtain health care services outside Texas and through the BlueCard Program, the coinsurance or co-share amount you pay is calculated based on either the billed charge the provider of health care charges for your covered services, or the "negotiated price" that the local Blue Cross and/or Blue Shield Plan passes on to Blue Cross and Blue Shield of Texas<sup>1</sup> ("BCBSTX"), whichever is *less*.

Below are some frequently asked questions that will help illustrate the claims calculation. For further information, you may write BCBSTX at P.O. Box 655488, Dallas, Texas, 75265-5488.

### ***What's a "negotiated price"?***

In many cases, the local Blue Cross and/or Blue Shield Plan obtains a discount from the provider's billed charges that is passed on to BCBSTX. A number of Plans can determine only an estimated price at the time your claim is paid. In addition, some Plans' provider contracts do not give a comparable discount for all claims. These Plans elect to smooth out the effect of their contracts by applying an average discount to BlueCard Program claims. Plans using these methods may prospectively adjust their estimated or average prices to correct for over- or underestimation of past prices.

### ***Give me an example of how you calculate my liability.***

Let's assume that you are on vacation in another state, you get sick, and you see a participating doctor for a particular medical service. Let's also assume your plan or policy requires you to pay 20% of the allowable amount (after a deductible). The particular doctor you receive services from has negotiated with the local Blue Cross and Blue Shield Plan a price of \$160, even though his standard charge for this service is \$200. The doctor bills the local Plan the standard charge of \$200, but we base your share of the claim on the negotiated price of \$160. In this case, the amount you pay (the "coinsurance" or "co-share amount") is \$32 (20% of \$160) rather than \$40 (20% of \$200).

### ***Does BlueCard always work this way?***

A few Blue Cross and/or Blue Shield Plans are governed by state laws that do not allow your coinsurance or co-share amount to be calculated using the "lesser of" the billed charge or the negotiated price. In those instances, BCBSTX will *recalculate* your claim using the "lesser of" formula and issue you a supplemental check if there is a difference of more than \$5. So, in the example above, if you were charged \$40 (20% of the billed charge of \$200) rather than \$32 (20% of the negotiated price), BCBSTX would send you a supplemental check for \$8 (the difference between \$40 you had to pay and \$32 you should have paid).

<sup>1</sup>An Independent Licensee of the Blue Cross and Blue Shield Association

## **Policyholder/Subscriber Liability Notice**

The following section is added to and made a part of the individual policy currently in force between Blue Cross and Blue Shield of Texas<sup>1</sup> (“BCBSTX”) and the Policyholder/Subscriber, or the booklet describing the benefits for participants of employer or association-sponsored medical plans:

### **Calculation of Participant Coinsurance Liability**

If you incur expenses under the Policy or Plan in a location outside of Texas and through the BlueCard Program, your liability for coinsurance or co-share will be calculated on the lesser of:

- the billed charge of the provider of health care, or
- the negotiated rate BCBSTX pays the local Blue Cross and/or Blue Shield Plan.

The negotiated rate may represent:

1. the actual price paid on the claim,
2. an estimated price that reflects adjusted aggregate payments expected to result from settlements or other non-claims transactions with one or more of the local Plan’s health care providers, or
3. a discount from billed charges representing the local Plan’s expected average savings for all of its providers or for a specified group of providers.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for overestimation or underestimation of past prices.

Some states’ statutes may require local Blue Cross and/or Blue Shield Plans to use a basis of computing your liability for coinsurance or co-share that does not reflect the entire discount. In those instances, BCBSTX will recalculate the amount of the claim using the “lesser of” methodology and adjust your coinsurance or co-share liability accordingly.

Understanding and acceptance of this amendment is deemed by Policyholder/Subscriber by payment of premium or other consideration in the month next following receipt of this amendment.

<sup>1</sup>An Independent Licensee of the Blue Cross and Blue Shield Association

## NOTICE

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

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

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

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

# **AMENDMENTS**

