Administered by:

BlueCross BlueShield of Texas

Your Health Care Benefits Program

City of Austin

Group #246682 – HMO Plan Network - Blue Essentials

Managed Health Care and Pharmacy Benefits

January 1, 2022

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SECTION 1 – OVERVIEW

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

The defined terms in this Plan Document are capitalized and shown in the appropriate provision in the Plan Document or in the *Glossary* and *Definitions* section of the Plan Document. Whenever these terms are used, the meaning is consistent with the definition given.

This Plan Document takes precedent over any other printed or electronic document.

The City of Austin reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This Plan Document is not to be construed as a contract of or for employment.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service	**1-888-907-7880**	**24 hours a day 7 days a week**
Website	**www.bcbstx.com/coa**	**24 hours a day 7 days a week**
Medical Prior Authorization	**1-800-441-9188**	**Monday – Friday 6:00 a.m. – 6:00 p.m.**
Mental Health/Substance Use Disorder Prior Authorization	**1-800-528-7264**	**24 hours a day 7 days a week**
Express Scripts Mail Order	**1-833-715-0942**	**24 hours a day 7 days a week**
Accredo Specialty	**1-833-721-1619**	**24 hours a day 7 days a week**
24/7 Nurseline	**1-800-581-0368**	**24 hours a day 7 days a week**
MDLIVE	**1-888-680-8646**	**24 hours a day 7 days a week**

Customer Service

1. Assists you in identifying your Plan Service Area.
2. Provides you information about Participating Providers contracting with Blue Cross Blue Shield of Texas.
3. Distributes claim forms.
4. Answers your questions on claims.
5. Assists you in identifying a Network Provider (but will not recommend specific Network Providers.)
6. Provides information on the features of the Plan.
7. Records comments about Providers.
8. Assists you with questions regarding the Pharmacy Benefits.

Benefits Value Advisor Program (BVA)

The BVA program has been established to assist Participants in navigating and maximizing their benefits under the Plan. BVAs are specially trained Customer Service representatives who assist Participants by comparing cost and providing information on Participating Providers for certain types of health care services.

SECTION 2 - INTRODUCTION

ELIGIBILITY

You are eligible to enroll in the Plan if you are an Employee in a regular scheduled budgeted position, a temporary Employee with more than 12 continuous months of service, a Retiree or Surviving Dependent.

Your eligible Dependents may also participate in the Plan.

An eligible Dependent is considered to be:

1. Your Spouse or Domestic Partner.
2. Your or your Spouse's child who is under age 26, including a natural child, stepchild, a legally adopted child, a grandchild who is an IRS dependent, a child placed for adoption or a child for whom you or your Spouse are the legal guardian.
3. Your child over the age of 26 who was covered as a Dependent at the time and is disabled and dependent upon you.
4. Your Domestic Partner's child who is under the age of 26. Your Domestic Partner must be enrolled in order to cover the child of the Domestic Partner.
5. A child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order.

Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse or Domestic Partner are both employed by the City of Austin, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. Only one parent may enroll your child as a Dependent.

COST OF COVERAGE

You and the City of Austin share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

ENROLLING IN COVERAGE

To enroll, contact the City of Austin Human Resources Department Employee Benefits Division herein referred to as the Employee Benefits Division within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you can enroll within 31 days of a qualifying life event or the next annual Open Enrollment.

During Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective January 1 of the following year.

CHANGING YOUR COVERAGE

You may make coverage changes during the year only if you experience a qualifying life event. The change in coverage must be consistent with the qualifying life event (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.)

The following are considered qualifying life events for purposes of the Plan:

1. Marriage, divorce or annulment.
2. Establishing or dissolution of a Domestic Partnership.
3. Birth, adoption, placement for adoption or legal guardianship of a child.
4. Change in your or your Spouse's employment or involuntary loss of health coverage.
5. Loss of coverage due to the exhaustion of another employer's Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) benefits, provided you were paying for premiums on a timely basis.
6. Death of a Dependent.
7. Dependent child no longer qualifying as an eligible Dependent.
8. Change in your or your Spouse's position or work schedule that impacts eligibility for health coverage.
9. Contributions were no longer paid by the employer (this is true even if you or your eligible Dependent continues to receive coverage under the prior plan and continue to pay the amounts previously paid by the employer.)
10. You or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent.
11. Benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent.
12. Termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact the Employee Benefits Division within 60 days of termination.)
13. You or your Dependent become eligible for premium assistance.
14. Subsidy under Medicaid or CHIP (you must contact the Employee Benefits Division within 60 days of determination of subsidy eligibility.)
15. A strike or lockout involving you or your Spouse or Domestic Partner.
16. A court or administrative order.

If you wish to change your elections, you must contact the Employee Benefits Division within 31 days of the qualifying life event. If you do not enroll within 31 days, you can enroll during the next annual Open Enrollment.

WHEN COVERAGE BEGINS

Once the Employee Benefits Division receives your completed enrollment form and the required documentation, coverage will begin on your date of hire. Retiree coverage starts on the first of the following month you retire. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the beginning of the next pay period or beginning of the month, provided you notify the Employee Benefits Division and complete an enrollment form within 31 days of your marriage.

Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the birth, adoption, or placement for adoption is finalized, provided you notify the Employee Benefits Division and complete an enrollment form within 31 days of the birth, adoption, or placement.

Coverage for a Dependent that loses coverage becomes effective the beginning of the next pay period or beginning of the month, provided you notify the Employee Benefits Division and complete an enrollment form within 31 days of loss of coverage.

If you are inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

Network benefits are available only if you receive covered health services from network Providers.

WHEN COVERAGE ENDS

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. When your coverage ends claims for Covered Health Services that you received before your coverage ended will still be paid.

Your coverage under the Plan will end on the earliest of, the end of the pay period or the end of the month if you are a Retiree:

1. The date your employment ends.
2. The date the Plan ends.
3. The date you stop making the required premium payments.
4. The date you are no longer eligible.
5. The date Blue Cross Blue Shield of Texas receives notice from the City of Austin to end coverage.

Coverage for your eligible Dependents will end on the earliest of:

1. The date your coverage ends.
2. The date you stop making the required premium contributions.
3. The date Blue Cross Blue Shield of Texas receives notice from the City of Austin to end coverage.

4. The last day of the month your Dependent child no longer qualifies as a Dependent under this Plan.

COVERAGE FOR A DISABLED CHILD

If an enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

1. The child is unable to be self-supporting due to a mental or physical handicap or disability.
2. The child depends mainly on you for more than 50% of support.
3. You provide to the Employee Benefits Division proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age.
4. You provide proof, upon the Employee Benefits Division's request, that the child continues to meet the conditions.

The proof might include medical examinations. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

SECTION 3 - HOW THE PLAN WORKS - HMO

ALLOWABLE AMOUNT

The Allowable Amount is the maximum amount of benefits Blue Cross Blue Shield of Texas will pay for Eligible Expenses you incur under the Plan. Blue Cross Blue Shield of Texas has established an Allowable Amount for Medically Necessary services, supplies, and procedures. When you choose to receive services, supplies, or care from a Provider that does not contract with Blue Cross Blue Shield of Texas, you will be responsible for the full amount. There is no Non-Network coverage for benefits, except for Emergency Health Services.

COVERAGE DETERMINATION

Certain services are covered pursuant to HMO medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by HMO when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbstx.com, or call customer service at the toll-free telephone number on the back of Your identification card.

UTILIZATION MANAGEMENT

Utilization Management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. Requirements for Medical Necessity may vary based upon Your plan benefits. Medically Necessary reviews may occur when a Provider requests a Prior Authorization before services are rendered. However, some services may require a Post-Service Medical Necessity Review if indicated by a medical policy.

Types of Utilization Management:

- Prior Authorization (includes out-of-network Referrals);
- Predetermination;
- Post-Service Medical Necessity Reviews.

Refer to the definition of Medically Necessary under the **DEFINITIONS** section of this Plan for additional information regarding any limitations and/or special conditions pertaining to Your benefits.

PRIOR AUTHORIZATION

Some Covered Services may also require Prior Authorization by HMO. Prior Authorization processes will be conducted in accordance with Texas Insurance Code, chapter 4201 or in accordance with the laws in the state of Texas. Renewal of an existing Prior Authorization issued by HMO can be requested by a Physician or Health Care Provider up to 60 days prior to the expiration of the existing Prior Authorization. For additional information and a current list of medical and health care services that require Prior Authorization, please visit the website at www.bcbstx.com.

PREDETERMINATION REVIEW

Predetermination is an optional Medical Necessity review by HMO of a medical procedure, treatment or test, that has been recommended by Your Physician in order to determine if it meets approved Blue Cross and Blue Shield medical policy guidelines. A Predetermination review is not the same as Prior Authorization. Prior Authorization is a required process for the Provider to get approval from HMO before You are admitted to the Hospital or for certain types of Covered Services. A Predetermination review can help You avoid unexpected out-of-pocket costs by determining ahead of time if a recommended service will be covered by Your health care plan. If a service requires Prior Authorization, a Predetermination review is not available.

Predetermination review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this benefit booklet. Please coordinate with Your Provider to submit a request for Predetermination.

Below are some examples (not an exhaustive list) o some common services for which a Predetermination review is recommended.

- certain higher cost Durable Medical Equipment;
- surgeries that might be considered cosmetic; and
- services and supplies that may be Experimental/Investigational under certain circumstances.

General Provisions Applicable to All Predeterminations

1. **No Guarantee of Payment**

   A Predetermination is not a guarantee of benefits or payment of benefits by HMO. Actual availability of benefits is subject to Your eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. Even if the service has been approved on Predetermination, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's benefits may have changed as of the date of service.

2. Request for Additional Information

The Predetermination process may require additional documentation from Your health care Provider or pharmacist. In addition to the written request for Predetermination, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by HMO to issue a Predetermination pursuant to the terms and conditions of this benefit booklet.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review or Post-Service Claims request is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Your eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure service was Medically Necessary. A Post-Service Medical Necessity Review may be available when a Prior Authorization was not required but a Medical Necessity review was required due to medical policy.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of payment. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of HMO. Post-Service Medical Necessity Review does not guarantee payment of benefits by HMO, for instance You may become ineligible as of the date of service or Your benefits may have changed as of the date of service.

2. Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from Your health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the plan to make a determination of coverage pursuant to the terms and conditions of HMO.

ACCESSING BENEFITS

Selecting a Primary Care Physician (PCP)

At the time you enroll, you must choose a PCP. If any Participant is a minor or otherwise incapable of selecting a PCP, the Subscriber should select a PCP on the Participant's behalf. If your Dependents enroll, you and your Dependents must choose a PCP to receive Covered Health Services. For the most current list of Participating Providers visit the website at **www.bcbstx.com/coa**. You may also call Customer Service at the number on the back of your ID card. Blue Cross Blue Shield of Texas may assign a PCP if one has not been selected. Until a PCP is selected or assigned, benefits will be limited to coverage for Emergency Care, Urgent Care, and Virtual Visits.

Your PCP

Your PCP coordinates your medical care, as appropriate, either by providing treatment or by issuing Referrals to direct you to Participating Providers. Except for Emergency Care/medical emergencies, Urgent Care, Virtual Visits or certain direct-access Specialist Physician benefits described in this Plan, only those services which are provided by or referred by your PCP will be covered. It is your responsibility to consult with the PCP in all matters regarding your medical care.

If your PCP performs, suggests, or recommends a course of treatment for you that includes services that are not Covered Health Services, the entire cost of any such non-Covered Services will be your responsibility.

Female Participants may select an Obstetrician/Gynecologist (OB/GYN) as their PCP for:

1. Well woman exams
2. Obstetrical care
3. Care for all active gynecological conditions
4. Diagnosis, treatment, and Referral for any disease or condition within the scope of the professional practice of the OB/GYN.

Changing Your PCP

You may change your PCP by calling the Customer Service number on the back of your ID card to make the change. The change will become effective on the first day of the month following the Blue Cross Blue Shield of Texas's receipt and approval of the request.

In the event of termination of a Participating Provider of any kind, Blue Cross Blue Shield of Texas will use best efforts to provide reasonable advance notice to Participants receiving care from such Participating Provider that termination is imminent. Special circumstances may render you eligible to continue receiving treatment from a Participating Provider after the effective date of termination, which is fully described in **Continuity of Care.**

Continuity of Care

If you are under the care of a Participating Provider who stops participating in HMO's network, Blue Cross Blue Shield will continue coverage for that Provider's Covered Health Services if all the following conditions are met:

1. You have a disability, acute condition, life-threatening illness or are past the thirteenth (13th) week of pregnancy; and
2. The Provider submits a written request to Blue Cross Blue Shield of Texas to continue coverage of your care that identifies the condition for which you are being treated and indicates that the Provider reasonably believes that discontinuing treatment could cause you harm; and
3. The Provider agrees to continue accepting the same reimbursement that applied when participating in HMO's network, and not to seek payment from you for any amounts for which you would not be responsible if the Provider were still participating in HMO's network.

Continuity coverage shall not extend for more than 90 days (or more than nine (9) months if you have been diagnosed with a terminal illness) beyond the date the Provider's termination takes effect. If you are past the thirteenth (13th) week of pregnancy when the Provider's termination takes effect, coverage may be extended through delivery, immediate postpartum care and the follow-up check-up within the first six (6) weeks of delivery.

Provider Referrals

A Referral is specific directions or instructions from your PCP, in conformance with Blue Cross Blue Shield of Texas's policies and procedures that direct you to a Participating Provider for Medically Necessary care. Your PCP coordinates your medical care, as appropriate, either by providing treatment or by issuing Referrals to direct you to Participating Providers. Except for Emergency Care/medical emergencies, Urgent Care, Virtual Visits, and Convenience Care Clinics, your PCP or OB/GYN must authorize referrals in advance. When your PCP refers you for care, this helps ensure that you receive care that is medically necessary and appropriate. If your PCP or OB/GYN cannot render the services you require, then the PCP or OB/GYN will refer you to the provider(s) you need. Your PCP or participating OB/GYN will establish a referral for you for any required obstetric/gynecologic specialty care. It is your responsibility to consult with the PCP in all matters regarding your medical care.

Services received from any Provider without a Referral from your PCP will not be covered, except in emergency situations or for OB/GYN services provided by a participating OB/GYN in your network. Any Referral services will be subject to all of the terms, conditions, limitations and exclusions of this Plan.

Inpatient Care by Non-PCP

During an inpatient stay at a Participating Hospital, Skilled Nursing Facility or other Participating facility, it may be appropriate for a Physician other than your PCP to direct

and oversee your care, if your PCP does not do so. However, upon discharge, you must return to the care of your PCP or have your PCP coordinate care that may be Medically Necessary.

If You elect to use out-of-network Providers for non-Emergency Care services and supplies available from Participating Providers, benefits will not be covered. Network Benefits
To receive Network Benefits as indicated on your *Schedule of Benefits*, you must choose Providers within the Network (other than for emergencies.) The Network has been established by Blue Cross Blue Shield of Texas and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. You may access our website, **www.bcbstx.com/coa**, for the most current listing to assist you in locating a Provider. The listing may change occasionally, so make sure the Providers you select are still Network Providers.

To receive Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Substance Use Disorder all inpatient and certain outpatient care Prior Authorization should be received by calling the Mental Health indicated on the back of your ID card and in this Plan Document. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Substance Use Disorder must be provided by Network Providers that have specifically contracted with Blue Cross Blue Shield of Texas to furnish services and supplies for those types of conditions to be considered for In-Network Benefits.

Only services that are performed, prescribed, directed or authorized in advance by the PCP or the Blue Cross Blue Shield of Texas are covered benefits under this Plan except Emergency Care, Urgent Care, and Virtual Visits.

If you choose a Network Provider, the Provider will bill Blue Cross Blue Shield of Texas for services provided.

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

1. The billed charges.
2. The Allowable Amount as determined by Blue Cross Blue Shield of Texas.
3. Other contractually determined payment amounts.

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

PROVIDER NETWORK

Tier-1 Network Benefits

These benefits apply to Covered Health Services that are provided by a Network Physician or other Provider that is identified as a Tier 1 Provider. Only certain Physicians and Providers have been identified as a Tier 1 Provider. Tier 1 Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits*.

Generally, when you receive Covered Health Services from a Tier 1 Provider, you pay less than you would if you receive the same care from a Network Provider. When these benefits apply, they are included in and subject to the same Out-of-Pocket Maximum and requirements as all other Covered Health Services provided by Network Providers.

Network Benefits

These benefits apply to Covered Health Services that are provided by a Network Physician or other Network Provider.

Emergency Health Services are always paid as Network Benefits. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, Radiologist, Anesthesiologist or Pathologist.

NON-NETWORK BENEFITS (Out-of-Network)

You may obtain Covered Health Services from Providers who are not part of the HMO's network of Participating Providers when receiving Emergency Care and Urgent Care.

If Inpatient Hospital Services are required after receiving Emergency Care and post stabilization care at a non-Participating Hospital, you must notify HMO within forty-eight (48) hours of receiving Emergency Care, or as soon as possible without being medically harmful or injurious to You. HMO will review the Medical Necessity and Participating Provider availability of the Inpatient Hospital Services. If HMO determines the Inpatient Hospital Services are not Medically Necessary or are available from a Participating Provider, or if You do not notify HMO within forty-eight hours, benefits at the non-Participating Hospital will not be covered.

If Covered Health Services are not available from Participating Providers within the access requirements established by law and regulation, Blue Cross Blue Shield of Texas will allow a Referral by your PCP to a non-Participating Provider, if approved by Blue Cross Blue Shield of Texas.

You will not be required to change your PCP or Participating Specialist Providers to receive Covered Health Services that are not available from Participating Providers within the Limited Provider Network, but the following apply.

1. The request must be from a Participating Provider.
2. Reasonably requested documentation must be received by Blue Cross Blue Shield of Texas.
3. The Referral will be provided within an appropriate time, not to exceed five business days, based on the circumstances and your condition.
4. When Blue Cross Blue Shield of Texas has allowed Referral to a non-Participating Provider, Blue Cross Blue Shield of Texas will reimburse the non-Participating Provider at the usual and customary rate or otherwise agreed rate, less the applicable Copayment(s). You are responsible only for the Copayments/ for such Covered Health Services.

5. Before Blue Cross Blue Shield of Texas denies a Referral, a review will be conducted by a Specialist of the same or similar specialty as the type of Provider to whom a Referral is requested.

When Covered Health Services are received from a non-Network Provider, Eligible Expenses are determined, based on: Negotiated rates agreed to by the non-Network Provider and either Blue Cross Blue Shield of Texas or one of Blue Cross Blue Shield of Texas's vendors, affiliates or subcontractors, at Blue Cross Blue Shield of Texas's discretion.

BALANCE BILLING AND OTHER PROTECTIONS

Federal requirements, including but not limited to the Consolidated Appropriations Act, may impact your benefits. BCBSTX will apply federal requirements to your Plan, where applicable. For some types of Out-of-Network care, your health care Provider may not bill you more than your Network cost-sharing levels. If you receive the types of care listed below, your cost-share will be calculated as if you received services from a Network Provider. Those cost-share amounts will apply to any Network Deductible and Out-of-Pocket Maximums.

1. Emergency Care from facilities or Providers who do not participate in your network;
2. Care furnished by non-participating Providers during your visit to a Network facility; and
3. Air ambulance services from non-participating Providers, if your plan covers Network air ambulance services.

There are limited instances when an Out-of-Network Provider of the care listed above may send you a bill for up to the amount of that Provider's billed charges. You are only responsible for payment of the Out-of-Network Provider's billed charges if, in advance of receiving services, you signed a written notice that informed you of:

1. The Provider's Out-of-Network status;
2. In the case of services received from an Out-of-Network Provider at a Network facility, a list of Network Providers at the facility who could offer the same services;
3. Information about whether Prior Authorization or other care management limitations may be required in advance of services; and
4. A good faith estimate of the Provider's charges.

Your Provider cannot ask you to be responsible for paying billed charges for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other specialists as may be defined by applicable law.

PAYMENT TERMS AND DESCRIPTIONS

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by Blue Cross Blue Shield of Texas. Charges for services and supplies which Blue Cross Blue Shield of Texas determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy the Out-of-Pockets Maximums.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services by Tier 1 or Network Providers. The Copay is a flat dollar amount and is paid at the time of service or when billed by the Provider. Copays count toward the Out-of-Pocket Maximum. If the Eligible Expense is less than the Copay, you are only responsible for paying the Eligible Expense and not the Copay.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each Calendar Year for Covered Health Services. If your eligible out-of-pocket expenses in a Calendar Year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the Calendar Year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in *Outpatient Prescription Drugs*.

The following table identifies what does and does not apply toward your Out-of-Pocket Maximum:

Plan Features	**Applies to the Out-of-Pocket Maximum?**
Copays, Coinsurance, and Deductible, even those for Covered Health Services available in *Outpatient Prescription Drugs*	Yes
Charges for non-Covered Health Services, including services received without a PCP Referral	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization as required	No
Charges that exceed Eligible Expenses	No

SECTION 4 – WELL BEING MANAGEMENT AND PRIOR AUTHORIZATION

CARE MANAGEMENT

When you seek prior authorization as required, Blue Cross Blue Shield of Texas will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

If you are living with a chronic condition or dealing with complex health care needs, Blue Cross Blue Shield of Texas may assign to you a Health Advisor, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Health Advisor will provide you with their telephone number, so you can call them with questions about your conditions, or your overall health and well-being.

Inpatient care management - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.

PRIOR AUTHORIZATION

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

If care is not available from Network Providers as determined by Blue Cross Blue Shield of Texas, and Blue Cross Blue Shield of Texas acknowledges your visit to an Out-of-Network Provider prior to the visit, In-Network Benefits will be paid.

Once the authorization has been obtained please review so that you understand what services have been authorized and what Providers are authorized to deliver the services that are subject to the authorization.

To obtain Prior Authorization, call the number on the back of your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

The following types of services require Prior Authorization. This is not meant to be an all-inclusive list. Please call Customer Service if you have questions.

1. All inpatient Hospital Admissions.
2. Extended Care Expenses.
3. Home Health.
4. Home Infusion Therapy.
5. Home Hospice.
6. Molecular Genetic Testing.
7. Outpatient Radiation Therapy.
8. Dialysis obtained from an Out-of-Network Provider.
9. Outpatient Transplant Evaluations.
10. Non-Emergency Fixed-Wing Air Ambulance Transportation.
11. Outpatient Procedures/Services Cardiac (heart related):
    - Cardiology.
    - Cardiac advanced imaging.
    - Stress testing (myocardial perfusion imaging - single-photon emission computed tomography SPECT and PET.
    - Cardiac CT and MRI.
    - Echocardiography (stress, transthoracic and transesophageal.)
12. Implantable Device Services: pacemakers, implantable cardioverter-defibrillators.
13. Lipid Apheresis, Ears, Nose and Throat (ENT):
    - Bone conduction hearing aids.
    - Cochlear implant.
    - Nasal and sinus surgery, Gastroenterology (Stomach.)
14. Gastric Electrical Stimulation (GES), Neurological:
    - Deep brain stimulation.
    - Sacral nerve neuromodulation/stimulation.
    - Vagus Nerve Stimulation (VNS.)
15. Orthopedic (Musculoskeletal.):
    - Artificial intervertebral disc.
    - Functional Neuromuscular Electrical Stimulation (FNMES.)
    - Lumbar spinal fusion.
    - Orthopedic applications of stem-cell therapy.
    - Spinal decompression and fusion surgeries.
    - Total disc replacement surgery.
    - Pneumatic compression devices - Durable Medical Equipment (DME.)
16. Radiology:
    - Advanced Imaging Services: MRI, Magnetic Resonance Angiogram (MRA), PET, PET- CT, CT, Computed Tomography Angiography (CTA), nuclear medicine (including Cardiology.)
    - Diagnostic ultrasound: head and neck, pediatric, breast, abdomen and retroperitoneum, extremity, arterial and venous.

17. Sleep Medicine:
    - Diagnostic Attended sleep studies and home sleep testing.
    - Positive Airway Pressure (PAP) therapy devices and supplies; (Sleep CPAP and BiPAP machines.)
    - Positive Airway Pressure (PAP) therapy compliance monitoring and intervention for non-compliance.
18. Surgical Procedures:
    - Orthognathic surgery; face reconstruction.
    - Mastopexy, breast lift.
    - Reduction mammoplasty; breast reduction.
19. Specialty Pharmacy:
    - Medical Benefit Specialty Drugs (Specialty Drugs administered by your Provider.)
    - Wound Care.
    - Hyperbaric oxygen (HBO2) therapy.
20. All inpatient treatment of Mental Health Care/Serious Mental Illness including partial hospitalization programs and treatment received at Residential Treatment Centers.
21. All inpatient treatment of Substance Use Disorder (SUD) including partial hospitalization programs and treatment received at Residential Treatment Centers.
22. If you transfer to another facility or to or from a specialty unit within the facility.
23. Outpatient treatment of Mental Health Care, Serious Mental Illness and Substance Use Disorder (SUD):
    - Psychological Testing or Neuropsychological Testing.
    - Applied Behavioral Analysis.
    - Electroconvulsive Therapy.
    - Intensive Outpatient Program.
    - Repetitive Transcranial Magnetic Stimulation.

Prior Authorization for Inpatient Hospital Admissions

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

Your Network Provider is required to obtain Prior Authorization for any inpatient admissions. If Prior Authorization is not obtained, the Network Provider will be sanctioned based on Blue Cross Blue Shield of Texas's contractual agreement with the Provider, and you will be held harmless for the Provider sanction.

If the Physician or Provider of services is not a Network Provider then you, your Physician, the participating Provider of services, or a family member should obtain Prior Authorization by calling one of the numbers shown on the back of your ID card. The call should be made between 6:00 a.m. and 6:00 p.m., Central Time, on business days and

9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and legal holidays. After working hours or on weekends, please call the **Medical Prior Authorization** number listed on the back of your ID card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

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

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

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

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

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

Prior Authorization for Extended Care Expenses and Home Infusion Therapy

Prior Authorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact Blue Cross Blue Shield of Texas to request Prior Authorization.

The request should be made:

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

Blue Cross Blue Shield of Texas will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Prior Authorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or

facility should call Blue Cross Blue Shield of Texas **Medical Prior Authorization** telephone number indicated in this Plan Document or shown on the back of your ID card.
If Blue Cross Blue Shield of Texas has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Prior Authorization for Mental Health Care, Serious Mental Illness, and Treatment of Substance Use Disorder

In order to receive maximum benefits, all inpatient treatment for Mental Health Care, Serious Mental Illness, and Substance Use Disorder must be Preauthorized by the Plan. Prior Authorization is also required for certain outpatient services. Outpatient services requiring Prior Authorization include psychological testing, neuropsychological testing, repetitive transcranial magnetic stimulation, Intensive Outpatient Programs, applied behavior analysis, and outpatient electroconvulsive therapy. Prior Authorization is not required for therapy visits to a Physician and/or Behavioral Health Practitioner.

To satisfy Prior Authorization requirements, you, a family member or your Behavioral Health Practitioner must call the **Mental Health/Substance Use Disorder Prior Authorization** number shown on the back of your ID card. The **Mental Health/Substance Use Disorder Prior Authorization** is available 24 hours a day, 7 days a week. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

However, if care is not available from Network Providers as determined by Blue Cross Blue Shield of Texas, and Blue Cross Blue Shield of Texas authorizes your visit to an Out-of- Network Provider to be covered at the Network Benefit level **prior to the visit**, Network Benefits will be paid, otherwise, no benefits will be paid.

When a treatment or service is Preauthorized, a length of stay or length of service is assigned. If you require a longer stay or length of service than was first Preauthorized, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.

Failure to Preauthorize

If Prior Authorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder is not obtained:

1. Blue Cross Blue Shield of Texas will review the Medical Necessity of your treatment or service prior to the final benefit determination.
2. If Blue Cross Blue Shield of Texas determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.

3. You may be responsible for a penalty in connection with the following Covered Services, if indicated on your *Schedule of Benefits*:
   - Inpatient Hospital Admission.
   - Inpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder.

Network Providers are responsible for satisfying the Prior Authorization requirements for any inpatient admissions. If Prior Authorization is not obtained, the Network Provider will be sanctioned based on Blue Cross Blue Shield of Texas contractual agreement with the Provider and no penalty charges will be deducted. The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

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

Mental Health/ Substance Use Disorder Prior Authorization

To satisfy Prior Authorization requirements for Participants seeking treatment for Behavioral Health Services, Mental Health Care, Serious Mental Illness, and Substance Use Disorder; you, your Behavioral Health Practitioner, or a family member may call the **Mental Health/Substance Use Disorder Prior Authorization** on the back of your ID card 24 hours a day, 7 days a week.

Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before the Plan pays Benefits) the prior authorization requirements do not apply to you. Since Medicare is the primary payer, the Plan will pay as secondary payer as described in *Coordination of Benefits (COB.)* You are not required to obtain authorization before receiving Covered Health Services.

SECTION 5 – SCHEDULE OF BENEFITS

The following chart summarizes the coverage available under your Blue Essentials Plan. For details, refer to *Additional Coverage Details*. All Covered Health Services (except in emergencies) must be provided by or through your Participating Primary Care Physician/Practitioner, who may refer you for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Female Participants may visit a Participating OB/GYN Physician in their PCP's Provider network for diagnosis and treatment without a Referral from their PCP. Urgent Care, Virtual Visits and Retail/Convenience Care Clinics do not require Primary Care Physician/Practitioner Referral.

Plan Coverage	Tier 1 Network Participant Responsibility	Network Participant Responsibility	Out-of-Network Participant Responsibility
Individual Annual Out-of-Pocket Maximum	$4,750		No Coverage
Family Annual Out-of-Pocket Maximum	$9,500		No Coverage
Lifetime Maximum Benefits	Unlimited		No Coverage
Preventive Services	Plan pays 100%		No Coverage
Virtual Visits	$10 copay		No Coverage
Office Visit Primary Care (including telehealth and telemedicine visits)	$15 copay	$30 copay	No Coverage
Office Visit Specialist Care (including telehealth and telemedicine visits)	$40 copay	$60 copay	No Coverage
Mental Health Care Outpatient	$15 copay		No Coverage
Retail/Convenience Care Clinics	$25 copay		No Coverage
Urgent Care Services	$50 copay		No Coverage
Emergency Room	$350 copay		$350 copay
Outpatient Surgery	$750 copay	$1,000 copay	No Coverage
Hospital Inpatient	$1,500 copay	$2,500 copay	No Coverage
Ambulance Services Ground or Air	$300 copay		$300 copay
Allergy Services	50% coinsurance Office visit copay may apply		No Coverage
Injections	50% coinsurance Office visit copay may apply		No Coverage
Immunizations	Plan pays 100% Office visit copay may apply		No Coverage

Physical, Speech and Occupational Therapy, Registered Dietician	$50 copay	No Coverage
Chiropractic Care (20 visit limit)	$50 copay	No Coverage
Rehabilitation Services	$50 copay	No Coverage
Outpatient Diagnostic Services	Plans pays 100%	No Coverage
Home Health Care	$30 copay	No Coverage
Hospice Care	Plan pays 100%	No Coverage
Durable Medical Equipment	Plan pays 100%	No Coverage
Prosthetic-Orthotic Devices and Related Supplies	Plan pays 80%	No Coverage
Insulin Pump	$150 copay	No Coverage
CT, MRI, PET Scans	$150 copay	No Coverage
Hearing Aids	Plan pays 100%	No coverage
Routine Vision Exam	**In-Network**	**Out-Of-Network**
Optometrists	$25 copay	No Coverage
Ophthalmologists	$45 copay	No Coverage
Pharmacy Benefits	**In-Network**	**Out-Of-Network**
Affordable Care Act Preventive Drugs	Plans pays 100%	No Coverage
Tier 1 – Generic	$10 copay	No Coverage
Annual Deductible	$50 annual deductible for Tier 2 or Tier 3	No Coverage
Tier 2 – Preferred Brand Drugs	$35 copay or 20% of cost up to $70	No Coverage
Tier 3 – Non-Preferred Brand Drugs	$55 copay or 20% of cost up to $110	No Coverage
Mail Order – 90-day supply	Three copays for Tier 1, 2 or 3	No Coverage

SECTION 6 - ADDITIONAL COVERAGE DETAILS

This section supplements the *Schedule of Benefits*.

While the table provides you with Benefit limitations along with Copayment and Coinsurance information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must obtain prior authorization from Blue Cross Blue Shield of Texas as required. Services that are not covered are described in *Exclusions*.

AMBULANCE SERVICES - EMERGENCY ONLY
Emergency ambulance transportation by a licensed ambulance service to the nearest Hospital where Emergency health services can be performed. See *Glossary* for the definition of Emergency.

AMBULANCE SERVICES - NON-EMERGENCY
Transportation provided by licensed professional ambulance, other than air ambulance, (either ground or air ambulance, as Blue Cross Blue Shield of Texas determines appropriate) between facilities when the transport is:

1. From a non-Network Hospital to a Network Hospital.
2. To a Hospital that provides a higher level of care that was not available at the original Hospital.
3. To a more cost-effective acute care facility.
4. From an acute facility to a sub-acute setting.
5. From a Providers office to a higher level of care when the Provider determines Participant is not able to drive themselves to the location.

The Plan pays Benefits for Emergency treatment at the scene (paramedic services) without ambulance transportation.

CLINICAL TRIALS
Benefits are paid in accordance with the Affordable Care Act. While a clinical trial might be considered experimental, investigational, and/or unproven, routine care is provided during a qualifying clinical trial. Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying Clinical Trial. Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying Clinical Trial as defined by the researcher.

<u>Prior Authorization Requirement</u>
You must obtain Prior Authorization from Blue Cross Blue Shield of Texas as soon as the possibility of participation in a Clinical Trial arises. Failure to obtain prior authorization will reduce benefits to 50% of Eligible Expenses.

DENTAL SERVICES - ACCIDENT ONLY

Dental services are covered by the Plan when all of the following are true:

1. Treatment is necessary because of accidental damage.
2. Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
3. The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a sound, natural tooth. The Physician or dentist must certify that the injured tooth was:

1. A virgin or unrestored tooth.
2. A tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech.

Dental services for final treatment to repair the damage must meet the following:

1. Started within three months of the accident.
2. Completed within 12 months of the accident.

DIABETES SERVICES

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Services must be ordered by a Physician and provided by appropriately licensed or registered health care professionals.

Benefits also include medical eye examinations (dilated retinal examinations) and preventive foot care for diabetes.

Diabetic Self-Management Items

Insulin pumps and supplies, and continuous glucose monitors for the management and treatment of diabetes, based upon your medical needs. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment* (DME.) Benefits for blood glucose meters, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered under medical and are covered and described in *Outpatient Prescription Drugs*.

Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are subject to the limit stated under *Durable Medical Equipment* in this section.

DURABLE MEDICAL EQUIPMENT (DME)

The Plan pays for Durable Medical Equipment (DME) that meets each of the following:

1. Ordered or provided by a Physician for outpatient use.
2. Used for medical purposes.
3. Not consumable or disposable.
4. Not of use to a person in the absence of a disease or disability.

If more than one piece of DME can meet your functional needs, Benefits are available only for the most Cost-Effective piece of equipment.

Examples of DME include but are not limited to:

1. Equipment to assist mobility, such as a standard wheelchair.
2. A standard Hospital-type bed.
3. Oxygen concentrator units and the rental of equipment to administer oxygen.
4. Delivery pumps for tube feedings.
5. Compression stockings (limited to two pair per Calendar Year.)
6. External cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implants are covered IF hearing loss is related to a surgical procedure or injury. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital, Inpatient Stay*, *Rehabilitation Services, Outpatient Therapy* and *Surgery, Outpatient* in this section.
7. Braces, including necessary adjustments to shoes to accommodate braces. (Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage, except for foot orthotics and cranial banding. Dental braces are also excluded from coverage.)
8. Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters, and personal comfort items are excluded from coverage.)

Blue Cross Blue Shield of Texas provides Benefits only for a single purchase (including repair/ replacement) of a type of DME once every three Calendar Years.

EMERGENCY ROOM SERVICES

The Plan pays for services that are required to stabilize or initiate treatment in an Emergency. Services must be received on an outpatient basis at a Hospital or Alternate Facility.
If you are admitted inpatient to a Network Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Room Services. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Blue Cross Blue Shield of Texas is notified within two business days of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital.

If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

EYE EXAMINATIONS

The Plan pays Benefits for eye examinations received from a health care Provider in the Provider's office.

Benefits include one routine vision exam, including refraction, to detect vision impairment each Calendar Year.

Benefits are available for charges connected to the fitting of eyeglasses or contact lenses.

GENDER DYSPHORIA

Benefits for the treatment of Gender Dysphoria limited to the following services:

1. Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses as described under *Mental Health Services* in this section.
2. Cross-sex hormone therapy.
3. Cross-sex hormone therapy administered by a medical Provider (for example during an office visit) is provided under *Pharmaceutical Products – Outpatient* in the section.
4. Cross-sex hormone therapy dispensed from a pharmacy is provided under *Outpatient Prescription Drugs.*
5. Puberty suppressing medication injected or implanted by a medical Provider in a clinical setting.
6. Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
7. Surgery for the treatment for Gender Dysphoria, including the surgeries listed below:

   Male to Female:

   - Clitoroplasty (creation of clitoris.)
   - Labiaplasty (creation of labia.)
   - Orchiectomy (removal of testicles.)
   - Penectomy (removal of penis.)
   - Urethroplasty (reconstruction of female urethra.)
   - Vaginoplasty (creation of vagina.)

   Female to Male:

   - Bilateral mastectomy or breast reduction.
   - Hysterectomy (removal of uterus.)
   - Metoidioplasty (creation of penis, using clitoris.)
   - Penile prosthesis.
   - Phalloplasty (creation of penis.)
   - Salpingo-oophorectomy (removal of fallopian tubes and ovaries.)
   - Scrotoplasty (creation of scrotum.)
   - Testicular prosthesis.

- Urethroplasty (reconstruction of male urethra.)
- Vaginectomy (removal of vagina.)
- Vulvectomy (removal of vulva.)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements: For breast surgery a written psychological assessment from at least one qualified behavioral health Provider experienced in treating Gender Dysphoria must be provided by the Covered Person.

For genital surgery a written psychological assessment from at least two qualified behavioral health Providers experienced in treating Gender Dysphoria who have independently assessed the Covered Person must be provided and document that the Covered Person meets all of the following criteria:

1. Persistent, well-documented Gender Dysphoria.
2. Capacity to make a fully informed decision.
3. Must be 18 years or older.
4. If medical or mental health concerns are present, they must be well controlled.
5. Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
6. Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender.
7. The treatment plan is based on identifiable external sources.

HABILITATIVE SERVICES

Benefits for habilitative services are provided as stated under Rehabilitation Services - Outpatient Therapy and Spinal Treatment in *Additional Coverage Details* and are subject to the requirements stated below.

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living.

Habilitative services are skilled when all of the following are true:

1. Services are part of a treatment or maintenance plan Medically Necessary to maintain a Covered Person’s current condition or to slow further decline.
2. Ordered by a Physician and provided and administered by a licensed Provider.
3. Not for the purpose of assisting with activities of daily living.
4. Requires clinical training to be delivered safely and effectively.
5. Not Custodial Care.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

1. Treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
2. Initial or continued treatment must be proven.

Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative services. A service that does not help the Covered Person meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

The Plan may require a treatment plan, request medical records, or clinical notes, to allow the Plan to substantiate the initial or continued medical treatment.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices* in this section.

A Copay is required for speech therapy in home or in an office setting.

HEARING AIDS

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness.) Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

1. Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
2. Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Benefits are limited to one pair every 48 months.

HOME HEALTH CARE

Covered Health Services are services received from a Home Health Agency that are both of the following:

1. Ordered by a Physician.
2. Provided by or supervised by a registered nurse.

Benefits are available on a part-time, intermittent schedule and when skilled home health care is required.

Skilled home health care is skilled nursing, skilled teaching, and skilled rehabilitation services when all of the following are true:

1. Delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
2. Ordered by a Physician.
3. Not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing or transferring from a bed to a chair.
4. Requires clinical training in order to be delivered effectively.
5. Not Custodial Care.

Benefits are limited to 120 visits per Calendar Year. One visit equals four hours of Skilled Care services.

HOSPICE CARE

The Plan pays Benefits for hospice care that is recommended by a Physician. Benefits are available when hospice care is received from a licensed hospice agency including a Hospital. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, and respite care.

HOSPITAL – INPATIENT STAY

The plan pays for inpatient hospital stays. An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense shall include:

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

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

INJECTIONS RECEIVED IN A PHYSICIAN'S OFFICE

The Plan pays for Benefits for injections (including allergy injections) received in a Physician's office, subject to Coinsurance. A copay may apply if required and collected by the Physician’s office.

MATERNITY SERVICES

Benefits for Pregnancy are paid at the same level as Benefits for any other condition. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

A Maternity Program is available at no cost. To sign up, you should notify Blue Cross Blue Shield of Texas by calling the number on the back of your ID card during the first trimester, but no later than one month prior to the anticipated childbirth.

Blue Cross Blue Shield of Texas will pay Benefits for an Inpatient Stay of at least:

1. 48 hours for the mother and newborn child following a vaginal delivery.
2. 96 hours for the mother and newborn child following a cesarean section delivery.

Covered Services, which may require Preauthorization, include:

1. Prenatal visits.
2. Use of Hospital delivery rooms and related facilities.
3. A separate Hospital admission. Copay is required.
4. Copayment is not required for a newborn child at time of delivery. If a newborn child is discharged and readmitted to a Hospital more than five days after the date of birth, a separate Hospital admission Copayment for such readmission will be required.
5. Use of newborn nursery and related facilities.
6. Special procedures as may be Medically Necessary and authorized by the PCP or designated OB/GYN.
7. Postnatal visits - If the mother or newborn is discharged before the minimum hours of inpatient coverage have passed, Blue Cross Blue Shield of Texas provides coverage for Post-Delivery Care for the mother and newborn. Post-Delivery Care may be provided at the mother's home or a Participating Provider's office or facility. A newborn child will not be required to receive health care services only from Participating Providers if born outside the Service Area due to an emergency or born in a non-network facility to a mother who is not a Participant. Blue Cross Blue Shield of Texas may require the newborn to be transferred to a Participating facility, at Blue Cross Blue Shield of Texas's expense, when determined to be medically appropriate by the newborn's treating Physician.

If Prior Authorization is not obtained as required, or notification is not provided, Benefits will be reduced to 50% of Eligible Expenses.

These are federally mandated requirements under the *Newborns' and Mothers' Health Protection Act of 1996* which apply to this Plan. The Hospital or other Provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

MENTAL HEALTH SERVICES

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital or an Alternate Facility or in a Provider's office. All services must be provided by or under the direction of a properly qualified behavioral health Provider and authorized by Blue Cross Blue Shield of Texas or its designated Mental Health/Substance-Related and Addictive Disorders Administrator.

Benefits include the following levels of care:

1. Inpatient treatment.
2. Residential treatment.
3. Partial hospitalization/day treatment.
4. Intensive outpatient treatment.
5. Outpatient treatment. Services include the following:
1. Diagnostic evaluations, assessment and treatment planning.
2. Treatment and/or procedures.
3. Medication management and other associated treatments.
4. Individual, family and, group therapy.
5. Provider-based case management services.
6. Crisis intervention.

Benefits for behavioral health services are provided under the same terms and conditions applicable to this Plan’s medical and surgical Benefits.

NEUROBIOLOGICAL DISORDERS - AUTISM SPECTRUM DISORDER SERVICES

The Plan pays Benefits for behavioral services for Autism Spectrum Disorder including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) that are the following:

1. Focused on the treatment of core deficits of Autism Spectrum Disorder.
2. Provided by a Board-Certified Applied Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.
3. Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available as described under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following levels of care:

1. Inpatient treatment.
2. Residential treatment.
3. Partial hospitalization/day treatment.
4. Intensive outpatient treatment.
5. Outpatient treatment.

Services include the following:

1. Diagnostic evaluations, assessment and treatment planning.
2. Treatment and/or procedures.
3. Medication management and other associated treatments.
4. Individual, family and group therapy.
5. Provider-based case management services.
6. Crisis intervention.

Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA) for individuals diagnosed with autism.

The Mental Health/Substance-Related and Addictive Disorders Administrator provides administrative services for all levels of care.

NUTRITIONAL COUNSELING

The Plan will pay for Covered Health Services provided by a registered dietician in an individual session for Covered Persons.

Some examples of such medical conditions include, but are not limited to:

1. Diabetes mellitus.
2. Coronary artery disease.
3. Congestive heart failure.
4. Severe obstructive airway disease.
5. Gout (a form of arthritis.)
6. Renal failure.
7. Phenylketonuria (a genetic disorder diagnosed at infancy.)
8. Hyperlipidemia (excess of fatty substances in the blood.)

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

OBESITY SURGERY

The Plan covers surgical treatment of morbid obesity provided by or under the direction of a Physician provided all of the criteria are met:

1. You are over the age of 18 or, for adolescents, have achieved greater than 95% of estimated adult height AND a minimum Tanner Stage of 4.
2. You have a minimum Body Mass Index (BMI) of 40, or > 35 with at least 2 co-morbid condition presents:
    - Hypertension
    - Dyslipidemia
    - Type 2 diabetes
    - Coronary heart disease
    - Sleep Apnea

3. You use a Blue Distinction Plus facility.
4. You have completed a multi-disciplinary surgical preparatory regimen, which includes a psychological evaluation.
5. Six month physician supervised diet documented within the last two years.

One surgery per lifetime unless complications. Excess skin removal is not covered, unless medically necessary.

OSTOMY SUPPLIES

Benefits for ostomy supplies are limited to:

1. Pouches, face plates and belts.
2. Irrigation sleeves, bags and ostomy irrigation catheters.
3. Skin barriers.

Benefits are not available for gauze, adhesive, adhesive remover, deodorant, pouch covers, or other items not listed above.

OUTPATIENT SURGERY, DIAGNOSTIC AND THERAPEUTIC SERVICES

Outpatient Surgery

The Plan pays for Covered Health Services for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include only the facility charge and the charge for supplies and equipment. Benefits for the surgeon fees and facility-based Physician's fees related to outpatient surgery are described under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Outpatient Diagnostic Services

The Plan pays for Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility including:

1. Lab and radiology/X-ray.
2. Mammography testing.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related Physician Fees.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Outpatient Diagnostic/Therapeutic Services - CT Scans, PET Scans, MRI and Nuclear Medicine
The Plan pays for Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis.

Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related Physician Fees.

Outpatient Therapeutic Treatments
The Plan pays for Covered Health Services for therapeutic treatments received on an outpatient basis at a Hospital or facility, including dialysis, intravenous chemotherapy or other intravenous infusion therapy, and other treatments not listed above.

Benefits under this section include the facility charge, and the charge for required services, supplies and equipment. Benefits for facility-based Physician's fees related to these services are described under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

PHYSICIAN FEES FOR SURGICAL AND MEDICAL SERVICES
The Plan pays for Physician Fees for surgical procedures and other medical care received in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility or Physician house calls.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services* below.

PHYSICIAN'S OFFICE SERVICES - SICKNESS AND INJURY
Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by Blue Cross Blue Shield of Texas.

Benefits for preventive services are described under *Preventive Care Services* in this section.

PREVENTIVE CARE SERVICES
The Plan pays for preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early

detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
2. Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
3. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
4. With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

Preventive care benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by calling the number on the back of your ID card. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth.

Blue Cross Blue Shield of Texas will determine the following:

1. Which pump is the most cost effective.
2. Whether the pump should be purchased or rented.
3. Duration of a rental.
4. Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME Provider or Physician.
In addition to the services listed above, this preventive care benefit includes certain:

1. Routine lab tests.
2. Diagnostic consults to prevent disease and detect abnormalities.
3. Diagnostic radiology and nuclear imaging procedures to screen for abnormalities.
4. Breast cancer screening and genetic testing.
5. Tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your Provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

PROSTHETIC DEVICES

External prosthetic devices that replace a limb or an external body part, limited to:

1. Artificial arms, legs, feet and hands.
2. Artificial eyes, ears and noses.
3. Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998.* Benefits include mastectomy bras and lymphedema stockings for the arm.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a Physician. Except for items required by the *Women's Health and Cancer Rights Act of 1998*, Benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three Calendar Years.

RECONSTRUCTIVE PROCEDURES

Reconstructive procedures are services performed when a physical impairment exists, and the primary purpose of the procedure is to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a Cosmetic Procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Other services mandated by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any Covered Health Service. Call the number on the back of your ID card for additional information regarding coverage for mastectomy-related services.

REHABILITATION SERVICES - OUTPATIENT THERAPY

The Plan provides short-term outpatient rehabilitation services for:

1. Physical therapy.
2. Occupational therapy.
3. Speech therapy.
4. Post-cochlear implant aural therapy.
5. Vision therapy.
6. Cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident.
7. Pulmonary rehabilitation therapy.
8. Cardiac rehabilitation therapy.
9. Proton therapy related to cancer.

For all rehabilitation services, a licensed therapy Provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under Home Health Care. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits are available only for rehabilitation services that are expected to result in significant physical improvement in your condition within two months of the start of treatment.
The Plan will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Benefits are limited to:

1. Unlimited visits for physical therapy. (Medical claim review applies after 20 visits.) Massage Therapy is covered if part of physical therapy treatments.
2. Unlimited visits for occupational therapy. (Medical claim review applies after 20 visits.)
3. Unlimited visits for speech therapy, regardless of diagnosis.
4. Unlimited visits for pulmonary rehabilitation therapy. (Medical claim review applies after 30 visits.)
5. Unlimited visits for post-cochlear implant aural therapy.
6. Unlimited visits for cardiac rehabilitation therapy. (Medical claim review applies after 30 visits.)
7. Unlimited visits for cognitive rehabilitation therapy. (Medical claim review applies after 30 visits.)
8. Unlimited visits for vision therapy.
9. Three rounds of proton therapy related to cancer.

SKILLED NURSING FACILITY/INPATIENT REHABILITATION FACILITY SERVICES
The Plan pays for Covered Health Services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

1. Services and supplies received during the Inpatient Stay.
2. Room and board in a Semi-Private Room (a room with two or more beds.)

Benefits for Skilled Nursing is limited to 60 days per Calendar Year. There is no limit for Inpatient Rehabilitation Facility Services.

Benefits are available only for the care and treatment of an Injury or Sickness that would have otherwise required an Inpatient Stay in a Hospital. If you remain in a Skilled Nursing Facility after the Physician discharges you, or after you reach the period authorized by Blue Cross Blue Shield of Texas, you will be liable for all subsequent costs incurred.

SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES
Substance-Related and Addictive Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a Provider's office. All services must be provided by or under the direction of a properly qualified behavioral health Provider.

Benefits include the following levels of care:

1. Inpatient treatment.
2. Residential Treatment.
3. Partial Hospitalization/Day Treatment.
4. Intensive Outpatient Treatment.
5. Outpatient treatment.

Benefits include the following services:

1. Diagnostic evaluations, assessment and treatment planning.
2. Treatment and/or procedures.
3. Medication management and other associated treatments.
4. Individual, family and, group therapy.
5. Provider-based case management services.
6. Crisis intervention.

Contact the **Mental Health/Substance Use Disorder Prior Authorization** at 1-800-528-7264 for referrals to Providers and coordination of care.

TEMPOROMANDIBULAR JOINT (TMJ) SERVICES
The Plan pays for Covered Health Services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician. Coverage includes necessary diagnostic or surgical treatment required as a result of accident, trauma, congenital defect, developmental defect, or pathology.

Benefits are not available for charges or services that are dental in nature.

Services or supplies for orthognathic surgery are covered. Non-surgical or non-diagnostic services, including dental appliances are not covered.

TRANSPLANTATION SERVICES
The plan pays for Covered Health Services for organ and tissue transplants when ordered by a Physician. For Network Benefits, transplantation services must be received at a Blue Distinction Plus facility. Transplantation services provided outside of a Blue Distinction Center will not be covered. Benefits are available when the transplant meets the definition of a Covered Health Service, and is not an Experimental, Investigational or Unproven Service. Prior Authorization is required for all transplant services.

Examples of transplants for which Benefits are available include but are not limited to:

1. Bone marrow transplants (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. The search for bone marrow/stem cell from a donor who is not biologically related to the patient is a Covered Health Service only for a transplant received at a designated Provider.
2. Heart transplants.
3. Heart/lung transplants.
4. Lung transplants.
5. Kidney transplants.
6. Kidney/pancreas transplants.
7. Liver transplants.
8. Liver/small bowel transplants.
9. Pancreas transplants.
10. Small bowel transplants.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage, unless determined by Blue Cross Blue Shield of Texas to be a proven procedure for the involved diagnoses.

Under the Plan there are specific guidelines regarding Benefits for transplant services. Call the number on the back of your ID card for information about these guidelines.

Benefits are also available for cornea transplants however the cornea transplant does not need to be performed at a Blue Distinction Plus facility.

TRAVEL AND LODGING

Blue Cross Blue Shield of Texas will assist the patient and family with travel and lodging arrangements related to:

1. Congenital Heart Disease (CHD.)
2. Obesity surgery services.
3. Transplantation services.
4. Cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Blue Distinction Plus Facility.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Blue Distinction Plus facility.

Eligible expenses for lodging for the patient (while not hospitalized) and one companion are paid at a per diem (per day) rate of up to $50 for the patient or up to $100 for the patient and one companion.

If patient is a covered Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem (per day) rate up to $100.

A combined overall maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all cancer treatments, transplant procedures, CHD treatments and obesity surgery services during the entire period that person is covered under this Plan.

URGENT CARE CENTER SERVICES

The Plan pays for Covered Health Services received at an Urgent Care Center, as defined in the *Glossary*. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services* - Sickness and Injury.

SECTION 7 - EXCLUSIONS AND LIMITATIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a Provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in *Schedule of Benefits*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

ALTERNATIVE TREATMENTS

1. Acupuncture.
2. Acupressure.
3. Aromatherapy.
4. Hypnotism.
5. Massage therapy. This exclusion does not apply to massage therapy for which Benefits are provided as described under *Rehabilitation Services – Outpatient Only* in *Additional Coverage Details.*
6. Rolfing.
7. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Spinal Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Additional Coverage Details*.

COMFORT OR CONVENIENCE

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
   - Air conditioners
   - Air purifiers and filter
   - Batteries and battery chargers
   - Dehumidifiers
   - Humidifiers
6. Devices and computers to assist in communication and speech.

DENTAL

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia.)
   This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Additional Coverage Details.*
2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:
   - Extraction, restoration and replacement of teeth
   - Medical or surgical treatments of dental conditions
   - Services to improve dental clinical outcomes
     This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Additional Coverage Details.*
3. Dental implants.
4. Dental braces (orthodontics.)
5. Dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following:
   - Transplant preparation
   - Initiation of immunosuppressives
   - The direct treatment of acute traumatic Injury, cancer or cleft palate
     This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in *Additional Coverage Details*.
6. Treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a Congenital Anomaly.

DRUGS

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See *Outpatient Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drug Products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by Blue Cross Blue Shield of Texas), must typically be administered or directly supervised by a qualified Provider or licensed/certified health professional in an outpatient setting.

3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and administered in the Physician's office.
4. Over-the-counter drugs and treatments.
5. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
6. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product.
7. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a Calendar Year.
8. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per Calendar Year.
10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a Calendar Year.
11. Non- Food and Drug Administration (FDA) approved drugs.

EXPERIMENTAL OR INVESTIGATIONAL OR UNPROVEN SERVICES

Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in *Additional Coverage Details*.

FOOT CARE

1. Routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes.
2. Hygienic and preventive maintenance foot care.
3. Treatment of flat feet.

4. Treatment of subluxation of the foot.
5. Shoe orthotics, except for custom molded shoe inserts prescribed to treat a disease or illness of the foot.

GENDER DYSPHORIA – COSMETIC PROCEDURES

Cosmetic Procedures, including the following:

1. Abdominoplasty.
2. Blepharoplasty.
3. Breast enlargement, including augmentation mammoplasty and breast implants.
4. Body contouring, such as lipoplasty.
5. Brow lift.
6. Calf implants.
7. Cheek, chin, and nose implants.
8. Injection of fillers or neurotoxins.
9. Face lift, forehead lift, or neck tightening.
10. Facial bone remodeling for facial feminizations.
11. Hair removal.
12. Hair transplantation.
13. Lip augmentation.
14. Lip reduction.
15. Liposuction.
16. Mastopexy.
17. Pectoral implants for chest masculinization.
18. Rhinoplasty.
19. Skin resurfacing.
20. Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave. (Removal or reduction of the Adam's Apple)
21. Voice modification surgery
22. Voice lessons and voice therapy.

MEDICAL SUPPLIES AND APPLIANCES

1. Safety items for sports related activities.
2. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
   - Elastic stockings. (Compression stockings are covered under *Durable Medical Equipment)*
   - Ace bandages.
   - Gauze and dressings.
   - Syringes. (Covered under the *Outpatient Prescription Drugs*)
   - Diabetic test strips. (Covered under the *Outpatient Prescription Drugs*)
   - TENS units and related supplies.
3. Orthotic appliances that straighten or re-shape a body part, except as described under *Durable Medical Equipment.*

4. Any orthotic braces available over-the-counter.
5. Tubings and masks, except when used with Durable Medical Equipment.

MENTAL HEALTH, NEUROBIOLOGICAL DISORDERS - AUTISM SPECTRUM DISORDER AND SUBSTANCE-RELATED AND ADDICTIVE DISORDERS SERVICES

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Tuition for or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
5. Outside of initial assessment all unspecified disorders for which the Provider is not obligated to provide clinical rationale as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
6. Transitional Living services.

NUTRITION

1. Megavitamin and nutrition-based therapy.
2. Nutritional counseling for either individuals or groups, except as specifically described in *Additional Coverage Details*.
3. Enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU.) Infant formula available over-the-counter is always excluded.
4. Health education classes unless offered by Blue Cross Blue Shield of Texas or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

REPRODUCTION

1. The following infertility treatment-related services:
    - Storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue.
    - Donor services and Non-medical costs of oocyte or sperm donation. (e.g., donor agency fees)
    - Embryo or oocyte accumulation defined as a fresh oocyte retrieval prior to the depletion of previously banked frozen embryos or oocytes.
    - Natural cycle insemination in the absence of sexual dysfunction or documented cervical trauma.

- All costs associated with surrogate motherhood; non-medical costs associated with a gestational carrier.
- Ovulation predictor kits.

2. Surrogate parenting and host uterus.
3. Artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes.
4. Fetal reduction surgery.
5. The reversal of voluntary sterilization.

TRANSPLANTS

1. Health services for organ, multiple organ and tissue transplants, except as described in *Transplantation Services* in *Additional Coverage Details* unless Blue Cross Blue Shield of Texas determines the transplant to be appropriate according to Blue Cross Blue Shield of Texas's transplant guidelines.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under their plan.)
3. Health services for transplants involving permanent mechanical or animal organs.
4. Any solid organ transplant that is performed as a treatment for cancer.

TRAVEL

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. (Some travel expenses related to Covered Health Services received from a Blue Distinction Provider may be reimbursed at Blue Cross Blue Shield of Texas's discretion)

VISION AND HEARING

1. Purchase cost of eyeglasses, contact lenses (except with Keratoconus diagnosis.)
2. Fitting charge for eyeglasses.
3. Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery.

ALL OTHER EXCLUSIONS

1. Health services and supplies that do not meet the definition of a Covered Health Service by Blue Cross Blue Shield of Texas.
2. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
3. Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.

4. Charges in excess of Eligible Expenses or in excess of any specified limitation.
5. Growth hormone therapy.
6. Custodial Care.
7. Domiciliary care.
8. Private duty nursing provided on an outpatient basis.
9. Respite care.
10. Rest cures.
11. Psychosurgery.
12. Treatment of benign gynecomastia (abnormal breast enlargement in males.)
13. Medical and surgical treatment of excessive sweating (hyperhidrosis.)
14. Panniculectomy, abdominoplasty, thigh plasty, brachioplasty and mastopexy. This exclusion does not apply to coverage required by the *Women's Health and Cancer Rights Act of 1998* as described under *Reconstructive Procedures* in *Additional Coverage Details*.
15. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
16. Oral appliances for snoring.
17. Any charges prohibited by federal anti-kickback or self-referral statutes.
18. Any Related services to a non-covered service. Related services are: Services in preparation for the non-covered services. Services in connection with providing the non- covered. Hospitalization required to perform the non-covered services: Services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

SECTION 8 - CLAIMS PROCEDURES

PRESCRIPTION DRUG BENEFIT CLAIMS
If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

1. You are asked to pay the full cost of the Prescription Drug Product when you fill it and you believe that the Plan should have paid for it.
2. You pay a Copay/Coinsurance and you believe that the amount of the Copay/Coinsurance was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented, and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

IF YOUR PROVIDER DOES NOT FILE YOUR CLAIM
You can obtain a claim form by visiting **www.bcbstx.com/coa** or call the number on the back of your ID card.

After Blue Cross Blue Shield of Texas has processed your claim, you will receive payment for Benefits that the Plan allows.

For Out-of-Network pharmacies, there is no coverage.

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, Blue Cross Blue Shield of Texas reserves the right to make benefit payments to the Provider or the member, as Blue Cross Blue Shield of Texas elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

FORM OF PAYMENT OF BENEFITS
Payment of Benefits under the Plan shall be in cash or cash equivalents, or in the form of other consideration that Blue Cross Blue Shield of Texas in its discretion determines to be adequate. Where Benefits are payable directly to a Provider, such adequate consideration includes the forgiveness in whole or in part of amounts the Provider owes to other plans for which Blue Cross Blue Shield of Texas makes payments, where the Plan has taken an assignment of the other plans' recovery rights for value.

EXPLANATION OF BENEFITS (EOB)

Receipt of Claims by Blue Cross Blue Shield of Texas

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

After processing the claim, Blue Cross Blue Shield of Texas will notify the Participant by way of an Explanation of Benefits summary.

FILING OF CLAIMS

Claim Forms

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

Blue Cross Blue Shield of Texas 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

Contracting Providers will submit your claims directly to Blue Cross Blue Shield of Texas for services provided to you or any of your covered Dependents. To assist Providers in filing your claims, you should carry your ID card with you.

Mail-Order Program

When you receive Covered Drugs dispensed through the mail-order program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from the Blue Cross Blue Shield of Texas website at **www.bcbstx.com/coa**, or by calling the number on the back of your ID card.

Participant-Filed Claims – Medical Claims

If your Provider does not submit your claims, you will need to submit them to Blue Cross Blue Shield of Texas using a claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the Blue Cross Blue Shield of Texas website at **www.bcbstx.com/coa**, or by calling Customer Service at the number on the back of your ID card. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Copayment Amounts, Coinsurance, Out-of-Pocket 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.

Visit the Blue Cross Blue Shield of Texas website for claim forms and other useful information at **www.bcbstx.com/coa**.

Where to Mail Completed Claim Forms

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

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

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill Blue Cross Blue Shield of Texas. Written agreements between Blue Cross Blue Shield of Texas and some Providers may require payment directly to them.

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

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

Benefit Payments to a Managing Conservator

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

1. The third party is named in a court order as managing or possessory conservator of the child.
2. Blue Cross Blue Shield of Texas has not already paid any portion of the claim.

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

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

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

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to Blue Cross Blue Shield of Texas within 12 months of the date you receive the services or supplies, except for Prescription Drug claims which must be filed within 90 days of the date of purchase to qualify for reimbursement under Pharmacy Benefits. Claims submitted and received by Blue Cross Blue Shield of Texas after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by Blue Cross Blue Shield of Texas

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

After processing the claim, Blue Cross Blue Shield of Texas will notify the Participant by way of an *Explanation of Benefits* summary.

CLAIM DENIALS AND APPEALS

Determinations

When Blue Cross Blue Shield of Texas 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. Blue Cross Blue Shield of Texas will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between Blue Cross Blue Shield of Texas and the Plan Administrator.

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

Timing of Required Notices and Extensions for Initial Determinations

Separate schedules apply to the timing of required notices and extensions, depending on the type of Claim. There are four types of Claims as described below:

1. **Urgent Care Clinical Claim** is any Pre-Service Claim that requires Prior Authorization, as described in this Plan Document, for benefits for medical care or Treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or Treatment.
2. **Pre-Service Claim** is any non-urgent request for benefits with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

3. **Concurrent Care Claim** is a claim for a health benefit which Blue Cross Blue Shield of Texas, after having previously approved an ongoing course of treatment provided over a period of time or a specific number of treatments, subsequently reduces or terminates coverage for the treatments (other than by Plan amendment or termination) or a request to extend the course of the treatment beyond what was previously approved that is an Urgent Care Clinical Claim.
4. **Post-Service Claim** is any other claim for a benefit for a service that has been provided to you. Your Claim must be in a form acceptable to Blue Cross Blue Shield of Texas. Your Claim must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which Blue Cross Blue Shield of Texas may request in connection with services rendered to you.

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What is the general deadline for initial determination?	No later than 72 hours from receipt of the claim.	15 calendar days from receipt of the claim.	30 calendar days from receipt of the claim.	Must be provided sufficiently in advance to give you an opportunity to appeal and obtain a decision before the previously approved treatment is reduced or terminated. A request to extend an approved course of treatment that is an Urgent Care Clinical Claim will receive a response within 24 hours, if the request is made at least 24 hours prior to the expiration of the previously approved period or number of treatments. **Note:** If such request for extension is not made at least 24 hours prior to the expiration of the previously approved period of time or number of treatments, then the claim will be handled as an Urgent Care Clinical Claim. If a request to extend a course of treatment is not an Urgent Care Clinical Claim, the request may be treated as a new Pre-Service or Post-Service claim depending on the circumstances.

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What if additional information is needed?	You must be notified of the need for additional information to decide the claim within 24 hours of receipt of claim. You must be given 48 hours to respond.	If an extension is necessary because you failed to provide information necessary to decide the claim, notice of extension must specify the information needed. You must be given at least 45 calendar days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier.	If an extension is necessary because you failed to provide information necessary to decide the claim, notice of extension must specify the information needed. You must be given at least 45 calendar days to respond. The running of time for the initial claims determination is suspended until the end of the prescribed response period or until the information is received, whichever is earlier.	Not applicable.
What is the deadline if additional information is needed?	Not applicable.	If there is an extension, you must be notified of the decision no later than 15 calendar days after the Blue Cross Blue Shield of Texas receives a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier.	If there is an extension, you must be notified of the decision no later than 15 calendar days after the Blue Cross Blue Shield of Texas receives a response to the request for information or 15 calendar days after the end of the deadline for you to provide the information, whichever is earlier.	Not applicable.

NOTE: Improperly Filed Claims. For Pre-Service Claims which name a specific claimant, medical condition, and service or supply for which approval is requested and which are submitted to a representative of Blue Cross Blue Shield of Texas responsible for handling benefit matters, but which otherwise fail to follow the procedures for filing Pre-Service Claims, you will be notified on the failure within five days (within 24 hours in the case of an Urgent Care Claim) and of the proper procedures to be followed. The notice may be oral, but you may also request a written notice.

<u>If a Claim Is Denied or Not Paid in Full</u>

On occasion, Blue Cross Blue Shield of Texas may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by Blue Cross Blue Shield of Texas, then review this Plan Document 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 Blue Cross Blue

Shield of Texas and request a review of the decision as described in **Claim Appeal Procedures** below.

If the claim is denied in whole or in part, you will receive a written notice from Blue Cross Blue Shield of Texas with the following information, if applicable:

1. The reasons for the determination.
2. A reference to the Health Benefit Plan provisions on which the determination is based.
3. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary.
4. Information sufficient to identify the claim including the date of service, health care Provider, claim amount (if applicable), denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
5. In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s.)
6. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross Blue Shield of Texas.
7. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.
8. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge upon request.
9. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request.
10. In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited internal and external review procedures applicable to such claims. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification.
11. Contact information for any applicable office of health insurance consumer assistance or ombudsman.

Claim Appeal Procedures - Definitions

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide in response to a claim, Pre-Service Claim or Urgent Care Clinical Claims, or make payment for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by Blue Cross Blue Shield of Texas or your Employer and Blue Cross Blue Shield of Texas or your Employer reduces or terminates such treatment (other than by amendment or termination of

the Employer's benefit plan) before the end of the approved treatment period that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

"**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by Blue Cross Blue Shield of Texas or, if applicable, your Employer, at the completion of the internal review/appeal process of an Adverse Benefit Determination with respect to which the internal review/appeal process has been deemed exhausted.

Note: Expedited Internal and External Review of Urgent Care Claims
If your claim is an Urgent Care Claim, you have the right to an expedited review. You also have the right to request an expedited external review of your Urgent Care Claim at the same time you request expedited internal review.

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

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In Urgent Care Clinical Claim situations, a health care Provider may appeal on your behalf. With the exception of Urgent Care Clinical Claim situations, your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call Blue Cross Blue Shield of Texas at the number on the back of your ID card.

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

1. Within 180 days after you receive notice of a denial or partial denial of your claim, you must call or write to Blue Cross Blue Shield of Texas's Administrative Office. Blue Cross Blue Shield of Texas will need to know the reasons why you do not agree with the denial or partial denial. Send your appeal request to the address below:

   Claim Review Section
   Blue Cross Blue Shield of Texas
   P.O. Box 60044
   Dallas, TX 75266-
   0044

2. Blue Cross Blue Shield of Texas will honor telephone requests for information, however, such inquiries will not constitute a request for review.

In support of your claim review, you have the option of presenting evidence and testimony to Blue Cross Blue Shield of Texas. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information during the internal review process.

Blue Cross Blue Shield of Texas will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the internal review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a Final Internal Adverse Benefit Determination on the appeal is made in order to give you a chance to respond before the final determination is made. If the information is received so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, the time periods below for providing notice of Final Internal Adverse Benefit Determination will be tolled until such time as you have had a reasonable opportunity to respond. After you respond or have had a reasonable opportunity to respond but failed to do so, Blue Cross Blue Shield of Texas will notify you of the benefit determination in a reasonably prompt time taking into account the medical exigencies.

The appeal determination will be made by Blue Cross Blue Shield of Texas or, if required, by a Physician associated or contracted with Blue Cross Blue Shield of Texas and/or by external advisors, who were not involved in making the initial denial of your claim and the individuals who made the Adverse Benefit Determination will not conduct the appeal. Before you or your authorized representative may bring any action to recover benefits you must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by Blue Cross Blue Shield of Texas and, if applicable, your Employer.

If you have any questions about the claims procedures or the review procedure, write to Blue Cross Blue Shield of Texas's Administrative Office or call Customer Service at the number shown in this Plan Document or on the back of your ID card.

If you don't appeal on time, you lose your right to later object to the decision on the claim.
Timing of Appeal Determinations:

	Urgent Care Claim	**Pre-Service Claim**	**Post-Service Claim**
Deadline by which a claimant will be notified of an appeals decision	As soon as possible taking into account the medical exigencies, but no more than 72 hours after receipt of the request for review. **Note:** The request may be submitted in writing or orally.	Not later than 30 days after receipt of the request for review. (Not later than 15 days for each level if your Plan offers two levels of Internal review.)	Not later than 60 days after receipt of the request for review. (Not later than 30 days for each level if your Plan offers two levels of internal review.)

Note: Your Plan provides two levels of internal review; you must request the second level of review within 60 days after you receive the first level decision. Your request for second level review must be submitted to:

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

Notice of Appeal Determination

Blue Cross Blue Shield of Texas will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, by a written notice of the determination.

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

1. A reason for the determination.
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination.
3. Information sufficient to identify the claim including the date of service, health care Provider, claim amount (if applicable), denial codes with their meanings and the standards used. Diagnosis/treatment codes with their meanings and the standards used are also available upon request.
4. Information sufficient to identify the claim including the date of service, health care Provider, claim amount (if applicable), denial codes with their meanings and the standards used. Diagnosis/treatment codes with their meanings and the standards used are also available upon request.
5. In certain situations, a statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s.)
6. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Blue Cross Blue Shield of Texas.
7. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits.
8. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request.
9. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request.
10. A description of the standard that was used in denying the claim and a discussion of the decision.
11. Contact information for any applicable office of health insurance consumer assistance or ombudsman.

If Blue Cross Blue Shield of Texas's or, if applicable, your Employer's decision is to continue to deny or partially deny your claim or you do not receive timely decision and your claim meets the External Review Criteria below, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **Standard External Review** section below.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call Blue Cross Blue Shield of Texas at 1-888-907-7880. Blue Cross Blue Shield of Texas Customer Service is accessible from 8:00 a.m. to 8:00 p.m., Monday through Friday.

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

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call the number on the back of your ID card for contact information.

FEDERAL EXTERNAL REVIEW PROGRAM

External Review is available for Adverse Benefit Determinations and Final Adverse Benefit Determinations that involve rescission and determinations that involve medical judgment including, but not limited to, those based on requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or a covered benefit; determinations that a treatment is experimental or investigational; determinations whether you are entitled to a reasonable alternative standard for a reward under a wellness program; or a determination of compliance with the non-quantitative treatment limitation provisions of the *Mental Health Parity and Addiction Equity Act*.

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an Independent Review Organization (IRO.)

Standard External Review:

1. **Request for standard external review.** Within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from Blue Cross Blue Shield of Texas, you or your authorized representative must file your request for standard external review.
2. **Preliminary review.** Within five business days following the date of receipt of the external review request, Blue Cross Blue Shield of Texas must complete a preliminary review of the request to determine whether:

- You are, or were, covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided.
- The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the plan (e.g., worker classification or similar determination.).
- You have exhausted Blue Cross Blue Shield of Texas's internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the Exhaustion section below for additional information and exhaustion of the internal appeal process.
- You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within one business day after we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month external review request period (or 48 hours following receipt of the notice), whichever is later, to perfect the request for external review. If your claim is not eligible for external review, we will outline the reasons it is ineligible in the notice.

3. **Referral to Independent Review Organization (IRO.)** When an eligible request for external review is completed within the time period allowed, Blue Cross Blue Shield of Texas will assign the matter to an IRO. The IRO assigned will be accredited by URAC or by similar nationally recognized accrediting organization. Moreover, Blue Cross Blue Shield of Texas will ensure that the IRO is unbiased and independent. Accordingly, Blue Cross Blue Shield of Texas must contract with at least three IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection.) In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO must provide the following:

1. Utilization of legal experts where appropriate to make coverage determinations under the plan.
2. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
3. Within five business days after the date of assignment of the IRO, Blue Cross Blue Shield of Texas must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by Blue Cross Blue Shield of Texas to timely provide the documents and information must not delay the conduct of the external review. If Blue Cross Blue Shield of Texas fails to timely provide the documents and information, the

assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify Blue Cross Blue Shield of Texas and you or your authorized representative.

4. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to Blue Cross Blue Shield of Texas. Upon receipt of any such information, Blue Cross Blue Shield of Texas may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by Blue Cross Blue Shield of Texas must not delay the external review. The external review may be terminated as a result of the reconsideration only if Blue Cross Blue Shield of Texas decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, Blue Cross Blue Shield of Texas must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from Blue Cross Blue Shield of Texas.
5. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during Blue Cross Blue Shield of Texas's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
   - Your medical records.
   - The attending health care professional's recommendation.
   - Reports from appropriate health care professionals and other documents submitted by Blue Cross Blue Shield of Texas, you, or your treating Provider.
   - The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law.
   - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations.
   - Any applicable clinical review criteria developed and used by Blue Cross Blue Shield of Texas, unless the criteria are inconsistent with the terms of the plan or with applicable law.
   - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.
6. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to Blue Cross Blue Shield of Texas and you or your authorized representative.

7. The notice of final external review decision will contain:
   - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial.
   - The date the IRO received the assignment to conduct the external review and the date of the IRO decision.
   - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
   - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.
   - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either Blue Cross Blue Shield of Texas or you or your authorized representative.
   - A statement that judicial review may be available to you or your authorized representative.
8. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under *PHS Act section 2793*.
9. After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by Blue Cross Blue Shield of Texas, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

Reversal of plan's decision

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, Blue Cross Blue Shield of Texas must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review:

1. **Request for expedited external review.** You may request for an expedited external review with Blue Cross Blue Shield of Texas at the time you receive:
   - An Adverse Benefit Determination, if the Adverse Benefit Determination involved a medical condition of yours for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal
   - A Final Internal Adverse Benefit Determination, if the determination involved a medical condition of yours for which the timeframe for completion of a standard

- external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility

2. **Preliminary review**. Immediately upon receipt of the request for expedited external review, Blue Cross Blue Shield of Texas must determine whether the request meets the reviewability requirements set forth in the **Standard External Review** section above. Blue Cross Blue Shield of Texas must immediately send you a notice of its eligibility determination that meets the requirements set forth in **Standard External Review** section above.
3. **Referral to Independent Review Organization (IRO.)** Upon a determination that a request is eligible for external review following the preliminary review, Blue Cross Blue Shield of Texas will assign an IRO pursuant to the requirements set forth in the **Standard External Review** section above. Blue Cross Blue Shield of Texas must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.
   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during Blue Cross Blue Shield of Texas's internal claims and appeals process.
4. **Notice of final external review decision.** The assigned IRO will provide notice of the final external review decision, in accordance with the requirements set forth in the **Standard External Review** section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing verbal notice, the assigned IRO must provide written confirmation of the decision to Blue Cross Blue Shield of Texas and you or your authorized representative.

Determination

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if Blue Cross Blue Shield of Texas waives the internal review process or Blue Cross Blue Shield of Texas has failed to comply with the internal claims and appeals process other than a *de minimis* failure.

The internal review process will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as Blue Cross Blue Shield of Texas demonstrates that the violation was for good cause or due to matters beyond the control of Blue Cross Blue Shield of Texas and that the violation occurred in the context of an ongoing, good faith exchange of information between you and Blue Cross Blue Shield of Texas.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

Except as described above, you must exhaust the mandatory levels of appeal before you request external review or seek other legal recourse.

INTERPRETATION OF EMPLOYER'S PLAN PROVISIONS

The Plan Administrator has given Blue Cross Blue Shield of Texas 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.

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

LIMITATION OF ACTION

You cannot bring any legal action against the City of Austin or Blue Cross Blue Shield of Texas to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against the City of Austin or Blue Cross Blue

Shield of Texas, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against the City of Austin or Blue Cross Blue Shield of Texas.

You cannot bring any legal action against the City of Austin or Blue Cross Blue Shield of Texas for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the City of Austin or Blue Cross Blue Shield of Texas you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the City of Austin or Blue Cross Blue Shield of Texas.

SECTION 9 - COORDINATION OF BENEFITS (COB)

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

1. Another employer sponsored health benefits plan.
2. A medical component of a group long-term care plan, such as skilled nursing care.
3. No-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy.
4. Medical payment benefits under any premise's liability or other types of liability coverage.
5. Medicare or other governmental health benefits.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan. How much this Plan will reimburse you, if anything, will also depend in part on the allowable expense. The term, "allowable expense," is further explained below.

DETERMINING WHICH PLAN IS PRIMARY

Order of Benefit Determination Rules

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

1. This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
2. Another employer sponsored health benefits plan.
3. When you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first.
4. A plan that covers a person as an Employee pays benefits before a plan that covers the person as a dependent.
5. If you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first.
6. Your Dependent children will receive primary coverage from the parent whose birth date occurs first in a Calendar Year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
   - The parents are married or living together whether or not they have ever been married and not legally separated.
   - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If two or more plans cover a Dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered in the order of:

1. The parent with custody of the child.
2. The Spouse of the parent with custody of the child.
3. The parent not having custody of the child.
4. The Spouse of the parent not having custody of the child.

Plans for active Employees pay before plans covering laid-off or retired Employees.

The plan that has covered the individual claimant the longest will pay first.

Finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

WHEN THIS PLAN IS SECONDARY

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below:

1. The Plan determines the amount it would have paid based on the allowable expense.
2. The Plan pays the entire difference between the allowable expense and the amount paid by the primary plan as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Copay or Coinsurance payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the allowable expense.

<u>Determining the Allowable Expense If This Plan is Secondary</u>

When the Provider is a Network Provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the Provider is a network Provider for the primary plan and a non-Network Provider for this Plan, the allowable expense is the primary plan's network rate. When the Provider is a non-Network Provider for the primary plan and a Network Provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the Provider is a non-Network Provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges. If this plan is secondary to Medicare, please also refer to the discussion in the section below, titled *Determining the Allowable Expense When This Plan is Secondary to Medicare*.

WHEN A COVERED PERSON QUALIFIES FOR MEDICARE

Determining Which Plan is Primary

As permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

1. Employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare.)
2. Individuals with end-stage renal disease, for a limited period of time.
3. Disabled individuals under age 65 and their Dependents under age 65.
4. Employees age 65 or older and not eligible for Medicare.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the Provider accepts reimbursement directly from Medicare. If the Provider accepts reimbursement directly from Medicare, the Medicare approved amount is the charge that Medicare has determined that it will recognize and which it reports on an "explanation of Medicare benefits" issued by Medicare (the "EOMB") for a given service. Medicare typically reimburses such Providers a percentage of its approved charge – often 80%.

If the Provider does not accept assignment of your Medicare benefits, the Medicare limiting charge (the most a Provider can charge you if they don't accept Medicare – typically 115% of the Medicare approved amount) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the allowable expense.

As a Retiree or Spouse of a Retiree eligible for, but not enrolled in, Medicare A and B, or if you have enrolled in Medicare but choose to obtain services from a Provider that does not participate in the Medicare program, Benefits under this Plan will be paid on a secondary basis and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating Provider.

When calculating the Plan's Benefits in these situations, for administrative convenience Blue Cross Blue Shield of Texas in its sole discretion may treat the Provider's billed charges as the allowable expense for both the Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

MEDICARE CROSSOVER PROGRAM

The Plan offers a Medicare Crossover program for Medicare Part A and Part B and Durable Medical Equipment (DME) claims. Under this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses. Your Dependent will also have this automated crossover, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

Once the Medicare Part A and Part B and Durable Medical Equipment (DME) carriers have reimbursed your health care Provider, the Medicare carrier will electronically submit the

necessary information to Blue Cross Blue Shield of Texas to process the balance of your claim under the provisions of this Plan.

You can verify that the automated crossover took place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier.

This crossover process does not apply to expenses that Medicare does not cover. You must go on to file claims for these expenses.

For information about enrollment or if you have questions about the program, call the number on the back of your ID card.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. Blue Cross Blue Shield of Texas may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

Blue Cross Blue Shield of Texas does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Blue Cross Blue Shield of Texas any facts needed to apply those rules and determine benefits payable. If you do not provide Blue Cross Blue Shield of Texas the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

OVERPAYMENT AND UNDERPAYMENT OF BENEFITS

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Plan should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Employer may recover the amount in the form of salary, wages, or benefits payable under any Employer-sponsored benefit plans, including this Plan. The Employer also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care Provider, Blue Cross Blue Shield of Texas reserves the right to recover the excess amount from the Provider pursuant to *Refund of Overpayments.*

<u>Refund of Overpayments</u>

If the plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

1. The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
2. All or some of the payment the Plan made exceeded the Benefits under the Plan.
3. All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Plan. If the refund is due from a person or organization other than the Covered Person, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Plan; or (ii) future benefits that are payable in connection services provided to persons under other plans for which Blue Cross Blue Shield of Texas makes payments, pursuant to a transaction in which the Plan's overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 10 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement. Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. This is handled through the right of reimbursement.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

The following persons and entities are considered third parties:

1. A person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages.
2. Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages.
3. The Plan Sponsor (for example workers' compensation cases.)
4. Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no- fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
5. Any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

1. To cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner.
2. To notify the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
3. To provide any relevant information requested by the Plan.
4. To sign and/or deliver such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim.
5. To respond to requests for information about any accident or injuries.
6. To attend court appearances.
7. To obtain the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
8. To comply with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to take legal action against you. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical Providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

Benefits paid by the Plan may also be considered to be Benefits advanced.

If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid. The Plan's rights to recovery will not be reduced due to your own negligence.

Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to construe and enforce the terms of the Plan's subrogation and reimbursement rights and make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

RIGHT OF RECOVERY

The Plan also has the right to recover benefits it has paid on you or your Dependent's behalf that were:

1. Made in error.
2. Due to a mistake in fact.
3. Advanced during the time period of meeting the Calendar Year Deductible.
4. Advanced during the time period of meeting the Out-of-Pocket Maximum for the Calendar Year.
5. Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

OVERPAYMENTS

If the Plan or Blue Cross Blue Shield of Texas pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or it was made in error (“Overpayment”), your Plan or Blue Cross Blue Shield of Texas has the right to obtain a refund of the Overpayment amount from: (i) the

person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities, or organizations, including, but not limited to Network Providers or Out- of- Network Providers.

If no refund is received, your Plan and/or Blue Cross and Blue Shield of Texas (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

1. Any future benefit payment made to any person or entity under this Benefit Booklet, whether for the same or a different Participant; or
2. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program; or
3. Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy; or
4. Any future benefit payment, or other payment, made to any person or entity; or
5. Any future benefit payment owed to one or more Network or Out-of-Network Providers.

Further, Blue Cross Blue Shield of Texas has the right to reduce your benefit plan's payment to a Network Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan Overpayment to the same Network Provider and to remit the recovered amount to the other Blue Cross and Blue Shield's plan.

SECTION 11 - WHEN COVERAGE ENDS

CONTINUING COVERAGE THROUGH THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

If you lose your Plan coverage, you may have the right to extend it under COBRA. Continuation of coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if the City of Austin is subject to the provisions of COBRA.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

1. A Participant.
2. A Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law.
3. A Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events:

If Coverage Ends Because of the Following Qualifying Events:	**You May Elect COBRA:**		
	For Yourself	**For Your Spouse**	**For Your Child(ren)**
Your work hours are reduced.	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct.)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage.	29 months	29 months	29 months
You die.	N/A	36 months	36 months
You divorce (or legally separate.)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit.)	N/A	N/A	36 months
You become entitled to Medicare.	N/A	See following table	See following table
The City of Austin files for bankruptcy under Title 11, United States Code.	36 months	36 months	36 months

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events.	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires.	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan.	36 months

* *Your work hours are reduced, or your employment is terminated for reasons other than gross misconduct.*

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage and advise you of the monthly cost. Your monthly cost is the full cost, (includes both Participant and Employer costs), plus a 2% administrative fee, or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a Provider, inform that Provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage during Open Enrollment or due to a qualifying life event, as described under Changing Your Coverage.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

1. The date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent.

2. The date your enrolled Dependent would lose coverage under the Plan.
3. The date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

When the qualifying event is the end of employment or reduction of the Employee's hours, and the Employee became entitled to Medicare less than 18 months before the qualifying event, COBRA coverage for the Employee's Spouse and Dependents can last until 36 months after the date the Employee becomes entitled to Medicare. For example: if a covered Employee becomes entitled to Medicare eight months before the date his/her employment ends (termination of the employment is the COBRA qualifying event), COBRA coverage for his/her Spouse and children would last 28 months (36 months minus eight months.)

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60-day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide the Employee Benefits Division with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the City at P.O. Box 1088, Austin, TX 78767. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiaries, the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The *Trade Act of 2002* amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the *Trade Act of 1974*. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the

requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the *Trade Act of 1974*, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the *Trade Act of 1974* or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost but begins on the first day of the special second election period.

WHEN COBRA ENDS

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

1. The date, after electing continuation coverage, this coverage is first obtained under any other group health plan.
2. The date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare.
3. The date coverage ends for failure to make the first required premium payment (premium is not paid within 45 days.)
4. The date coverage ends for failure to make any other monthly premium payment (premium is not paid within 30 days of its due date.)
5. The date the entire Plan ends.
6. The date coverage would otherwise terminate under the Plan as described in the beginning of this section.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the *Uniformed Services Employment and Reemployment Rights Act of 1994*, as amended (USERRA.)

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons Blue Distinction by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 12 - OTHER IMPORTANT INFORMATION

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSOs)
A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the City of Austin will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

YOUR RELATIONSHIP WITH BLUE CROSS BLUE SHIELD OF TEXAS AND THE CITY OF AUSTIN
In order to make choices about your health care coverage and treatment, the City of Austin believes that it is important for you to understand how Blue Cross Blue Shield of Texas interacts with the Plan Sponsor's benefit Plan and how it may affect you. Blue Cross Blue Shield of Texas helps administer the Plan Sponsor's benefit plan in which you are enrolled. Blue Cross Blue Shield of Texas does not provide medical services or make treatment decisions. This means:

1. Blue Cross Blue Shield of Texas communicates to you, decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this Plan Document.)
2. The Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

The City of Austin and Blue Cross Blue Shield of Texas may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. The City of Austin and Blue Cross Blue Shield of Texas will use individually identifiable information about you as permitted or required by law, including in operations and in research. The City of Austin and Blue Cross Blue Shield of Texas will use de-identified data for commercial purposes including research.

RELATIONSHIP WITH PROVIDERS
The relationships between the City of Austin, Blue Cross Blue Shield of Texas and Network Providers are solely contractual relationships between independent contractors. Network Providers are not the City of Austin's agents or Employees, nor are they agents or Employees of Blue Cross Blue Shield of Texas. The City of Austin and any of its Employees are not agents or Employees of Network Providers, nor are Blue Cross Blue Shield of Texas and any of its Employees' agents or Employees of Network Providers.

The City of Austin and Blue Cross Blue Shield of Texas do not provide health care services or supplies, nor do they practice medicine. Instead, the City of Austin and Blue Cross Blue Shield of Texas arrange for health care Providers to participate in a Network and pay Benefits. Network Providers are independent practitioners who run their own offices and facilities. Blue Cross Blue

Shield of Texas's credentialing process confirms public information about the Providers' licenses and other credentials but does not assure the quality of the services provided. They are not the City of Austin's Employees nor are they employees of Blue Cross Blue Shield of Texas. The City of Austin and Blue Cross Blue Shield of Texas are not liable for any act or omission of any Provider.

Blue Cross Blue Shield of Texas is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

The City of Austin is solely responsible for:

1. Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage.)
2. The timely payment of the service fee to Blue Cross Blue Shield of Texas.
3. The funding of Benefits on a timely basis.
4. Notifying you of the termination or modifications to the Plan.

THE CLAIM ADMINISTRATOR'S OWNERSHIP INTERESTS

The Claim Administrator or its subsidiaries or affiliates may have ownership interests in certain Providers who provide covered services to Participants, and/or vendors or other third parties who provide covered services related to the benefits and requirements of this Plan or provide services to certain Providers.

YOUR RELATIONSHIP WITH PROVIDERS

The relationship between you and any Provider is that of Provider and patient, you:

1. Are responsible for choosing your own Provider.
2. Are responsible for paying, directly to your Provider, any amount identified as a member responsibility, including Copayments and Coinsurance and any amount that exceeds Eligible Expenses.
3. Are responsible for paying, directly to your Provider, the cost of any non-Covered Health Service.
4. Must decide if any Provider treating you is right for you (this includes Network Providers you choose and Providers to whom you have been referred.)
5. Must decide with your Provider what care you should receive.

Your Provider is solely responsible for the quality of the services provided to you. The relationship between you and City of Austin is that of Employer and Employee, Dependent or other classification as defined in this Plan Document.

INTERPRETATION OF BENEFITS

The City of Austin and Blue Cross Blue Shield of Texas have the sole and exclusive discretion to:

1. Interpret Benefits under the Plan.
2. Interpret the other terms, conditions, limitations and exclusions of the Plan, including this Plan Document and any Summary of Material Modifications and/or Amendments.
3. Make factual determinations related to the Plan and its Benefits.

The City of Austin and Blue Cross Blue Shield of Texas may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, the City of Austin may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that the City of Austin does so in any particular case shall not in any way be deemed to require the City of Austin to do so in other similar cases.

INFORMATION AND RECORDS

The City of Austin and Blue Cross Blue Shield of Texas may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. The City of Austin and Blue Cross Blue Shield of Texas may request additional information from you to decide your claim for Benefits. The City of Austin and Blue Cross Blue Shield of Texas will keep this information confidential. The City of Austin and Blue Cross Blue Shield of Texas may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish the City of Austin and Blue Cross Blue Shield of Texas with all information or copies of records relating to the services provided to you. The City of Austin and Blue Cross Blue Shield of Texas have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. The City of Austin and Blue Cross Blue Shield of Texas agree that such information and records will be considered confidential.

For complete listings of your medical records or billing statements the City of Austin recommends that you contact your health care Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from Blue Cross Blue Shield of Texas, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, the City of Austin and Blue Cross Blue Shield of Texas will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Blue Cross Blue Shield of Texas's designees have the same rights to this information as does the Plan Administrator.

INCENTIVES TO PROVIDERS

Network Providers may be provided financial incentives by Blue Cross Blue Shield of Texas to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network Providers are:

1. Bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness.
2. A practice called capitation which is when a group of Network Providers receives a monthly payment from Blue Cross Blue Shield of Texas for each Covered Person who selects a Network Provider within the group to perform or coordinate certain health services. The Network Providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives, you may contact the number on the back of your ID card. You can ask whether your Network Provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network Provider.

INCENTIVES TO YOU

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but the City of Austin recommends that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

WORKERS' COMPENSATION NOT AFFECTED

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

FUTURE OF THE PLAN

Although the Employer expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Employer's decision to terminate or amend a Plan may be due to changes in federal or state laws governing Employee benefits, the requirements of the Internal Revenue Code or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Employer does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Employer's decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Employer and others as may be required by any applicable law.

PLAN DOCUMENT

This Plan Document takes precedent over any other printed or electronic document.

SECTION 13 - GLOSSARY

Many of the terms used throughout this Plan Document may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this Plan Document, but it does not describe the Benefits provided by the Plan.

Addendum - any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this Plan Document and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and Plan Document and/or Amendments to the Plan Document, the Addendum shall be controlling.

Allowable Amount - the maximum amount determined by the Blue Cross Blue Shield of Texas to be eligible for consideration of payment for a particular service, supply or procedure rendered by a Participating Provider. The Allowable Amount is based on the provisions of the Participating Provider contract and the payment methodology in effect on the date of service, whether diagnostic related grouping (DRG), capitation, relative value, fee schedule, per diem or other.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

1. Surgical services.
2. Emergency Health Services.
3. Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient basis or inpatient basis (for example a Residential Treatment facility.)

Amendment - any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) - The amount of Covered Expenses that the Covered Person must pay in each Calendar Year before benefits are paid according to the Plan for any Covered Expenses incurred during the remainder of the Calendar Year. The Deductible is shown in the first table in the *Schedule of Benefits*.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Bariatric Services - are administered by Blue Cross Blue Shield of Texas or its affiliates made available to you by the City of Austin. The program provides:

1. Specialized clinical consulting services to Participants and enrolled Dependents to educate on obesity treatment options.
2. Access to specialized Network facilities and Physicians for obesity surgery services.

Benefits - plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Body Mass Index (BMI) - a calculation used in obesity risk assessment which uses a person's weight and height to approximate body fat.

Calendar Year - the period beginning January 1 of any year and ending December 31 of the same year.

Cancer Services - are administered by Blue Cross Blue Shield of Texas or its affiliates made available to you by the City of Austin and provides:

1. Specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer.
2. Access to cancer centers with expertise in treating the most rare or complex cancers.
3. Education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Chronic Kidney Disease (CKD) - a program administered by Blue Cross Blue Shield of Texas or its affiliates made available to you by City of Austin. The CKS program provides:

1. Specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease.
2. Access to dialysis centers with expertise in treating kidney disease.
3. Guidance for the patient on the prescribed plan of care.

Clinical Trial - a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA - see *Consolidated Omnibus Budget Reconciliation Act of 1985* (COBRA.)

Coinsurance - the charge, stated as a percentage of Eligible Expenses that you are required to pay for certain Covered Health Services as described *How the Plan Works* and *Outpatient Prescription Drugs*.

Congenital Anomaly - a physical developmental defect that is present at birth and is identified within the first 12 months of birth.

Congenital Heart Disease (CHD) - any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

1. Be passed from a parent to a child (inherited.)
2. Develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy.
3. Have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) - a federal law that requires employers to offer continued health insurance coverage to certain Employees and their dependents whose group health insurance has been terminated.

Convenience Care Clinic (Retail Health Clinic) - a facility that provides Covered Health Services that are walk-in clinics found in many large pharmacies and retail-based locations designed to treat simple conditions.

Copayment (or Copay) - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services as described in *How the Plan Works* and *Outpatient Prescription Drugs*.

For Covered Health Services, you are responsible for paying the lesser of the following:

1. The applicable Copayment.
2. The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by Blue Cross Blue Shield of Texas.

Cost-Effective - the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services - those health services, including services, supplies or Pharmaceutical Products, which Blue Cross Blue Shield of Texas determines to be:

1. Medically Necessary.
2. Described as a Covered Health Service in this Plan Document under *Schedule of Benefits* and *Additional Coverage Details* and *Outpatient Prescription Drugs*.
3. Provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in *Introduction*.
4. Not otherwise excluded in this Plan Document under *Exclusions* or *Outpatient Prescription Drugs.*

Covered Person - either the Participant or an enrolled Dependent, but this term applies only while the person is enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Plan Document are references to a Covered Person.

Custodial Care - services that are any of the following:

1. Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating.)

2. Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible - see Annual Deductible.

Dependent - an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

DME - see Durable Medical Equipment (DME.)

Domestic Partner the individual who lives in the same household and shares the common resources of life in a close, personal, intimate relationship with a City Employee If, under Texas law, the individual would be prevented from marrying the employee on account of age, consanguinity, or prior undissolved marriage to another person. A Domestic Partner may be of the same or opposite gender as the employee.

Domestic Partnership - a relationship between a Participant and one other person of the same or opposite sex. All of the following requirements apply to both persons:

1. They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
2. They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
3. They must be at least 18 years old.
4. They must share the same permanent residence and the common necessities of life.
5. They must be mentally competent to enter into a contract.
6. They must be financially interdependent.

The Participant and Domestic Partner must jointly sign an affidavit of Domestic Partnership provided by the Employee Benefits Division upon request.

Domiciliary Care - living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) - medical equipment that is all of the following:

1. Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
2. Is not disposable.
3. Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.

4. Can withstand repeated use.
5. Is not implantable within the body.
6. Is appropriate for use, and is primarily used, within the home.

Eligible Expenses - for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by Blue Cross Blue Shield of Texas as stated below and as detailed in *How the Plan Works*.

Eligible Expenses are determined solely in accordance with Blue Cross Blue Shield of Texas's reimbursement policy guidelines. Blue Cross Blue Shield of Texas develops the reimbursement policy guidelines, in Blue Cross Blue Shield of Texas's discretion, following evaluation and validation of all Provider billings in accordance with one or more of the following methodologies:

1. As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS.)
2. As reported by generally recognized professionals or publications.
3. As used for Medicare.
4. As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that Blue Cross Blue Shield of Texas accept.

Emergency - a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the Covered Person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

Emergency Health Services - with respect to an Emergency, both of the following:

1. A medical screening examination (as required under section *1867 of the Social Security Act, 42 U.S.C. 1395dd)* that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency.
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section *1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3).)*

Employee - a person who:

1. Is in a regular budgeted position with the Employer.
2. Is in a temporary position with 12 months of continuous employment.
3. Is an Employee of an affiliated employer with the Employer.

4. Is a retired Employee who meets all of the criteria established by the Employer in order to be eligible for continued coverage under this Plan after retirement.
5. Is a Participant covered under COBRA.

Employer - the City of Austin.

Experimental or Investigational Services - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time Blue Cross Blue Shield of Texas makes a determination regarding coverage in a particular case, are determined to be any of the following:

1. Not approved by the *United States Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
2. Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
3. The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions: Clinical Trials for which Benefits are available as described under *Clinical Trials* in *Additional Coverage Details*.

If you are not a participant in a qualifying Clinical Trial as described under *Additional Coverage Details* and have a Sickness or condition that is likely to cause death within one year of the request for treatment, Blue Cross Blue Shield of Texas may, at its discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, Blue Cross Blue Shield of Texas must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) - a statement provided by Blue Cross Blue Shield of Texas to you, your Physician, or another health care professional that explains:

1. The Benefits provided (if any.)
2. The allowable reimbursement amounts.
3. Copays.
4. Coinsurance.
5. Any other reductions taken.
6. The net amount paid by the Plan.
7. The reason(s) why the service or supply was not covered by the Plan.

Gender Dysphoria - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association***.**

Diagnostic criteria for adults and adolescents:
A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics.)
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics.)
3. A strong desire for the primary and/or secondary sex characteristics of the other gender.
4. A strong desire to be of the other gender (or some alternative gender different from one's assigned gender.)
5. A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender.)
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender.)
7. The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.

Diagnostic criteria for children:
A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender.)
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
7. A strong dislike of ones' sexual anatomy.
8. A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
9. The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning. Strong and persistent cross-gender identification (not merely a desire for any perceived cultural advantages of being the other sex.)

10. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.
11. The disturbance is not concurrent with a physical intersex condition.
12. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
13. The transsexual identity has been present persistently for at least two years.
14. The disorder is not a symptom of another mental disorder or a chromosomal abnormality.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Advisor - the primary nurse that Blue Cross Blue Shield of Texas may assign to you if you have a chronic or complex health condition. If a Health Advisor is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Health Statement(s) - a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution, operated as required by law and that meets both of the following:

1. It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance-related and addictive disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
2. It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Hospital Admission – the period between the time of a Participant's entry into a Hospital or a Substance Use Disorder Treatment Center as a *Bed patient* and the time of discontinuance of bed-patient care or discharge by the admitting Physician, Behavioral Health Practitioner 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. *Bed patient* means confinement in a bed accommodation of a Substance Use Disorder Treatment Center 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 Use Disorder Treatment Center) designed, staffed, and operated to provide long- term institutional care on a residential basis.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital Blue Distinction as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavior Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI.)*

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

1. Fewer than seven days each week.
2. Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

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

Medicaid - a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary/Medical Necessity - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by Blue Cross Blue Shield of Texas or its designee, within Blue Cross Blue Shield of Texas's sole discretion. The services must be:

1. In accordance with Generally Accepted Standards of Medical Practice.

2. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
3. Not mainly for your convenience or that of your doctor or other health care Provider.
4. Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms. BCBSTX does not determine course of treatment. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. Blue Cross Blue Shield of Texas reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within Blue Cross Blue Shield of Texas's sole discretion.
Blue Cross Blue Shield of Texas develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Services Disorders Services Administrator - the organization who provides or arranges Mental Health and Substance-Related and Addictive Disorders Services under the Plan.

Mental Illness - mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in *Exclusions*.

Network - when used to describe a Provider of health care services, this means a Provider that has a participation agreement in effect (either directly or indirectly) with Blue Cross Blue Shield of Texas or with its affiliate to participate in the Network; however, this does not include those Providers who have agreed to discount their charges for Covered Health Services by way of their participation with Blue Cross Blue Shield of Texas's affiliates are those entities affiliated with Blue Cross Blue Shield of Texas through common ownership or control with Blue Cross Blue Shield of Texas or with Blue Cross Blue Shield of Texas's ultimate corporate parent, including direct and indirect subsidiaries.

A Provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network Provider for only some products. In this case, the Provider will be a Network Provider for the Covered Health Services and products included in the participation agreement, and a non-Network Provider for other Covered Health Services and products. The participation status of Providers will change from time to time.

Network Benefits - for Benefit Plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network Providers. Refer to *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and *How the Plan Works*, for details about how Network Benefits apply.

Open Enrollment - the period of time, determined by City of Austin, during which eligible Participants may enroll themselves and their Dependents under the Plan. City of Austin determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every Calendar Year. Refer to *Schedule of Benefits* for the Out-of-Pocket Maximum amount. See *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant - a Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in *Introduction*. A Participant must live and/or work in the United States.

Participating - describes a Provider that has entered into a contractual agreement with Blue Cross Blue Shield of Texas for the provision of Covered Health Services to Participants.

Participating Pharmacy - an independent retail Pharmacy, or chain of retail Pharmacies, or a Specialty Pharmacy Provider which have entered into a written agreement with Blue Cross Blue Shield of Texas to provide pharmaceutical services to Participants under this Plan.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Any podiatrist, dentist, psychologist, chiropractor, optometrist or other Provider who acts within the scope of their license will be considered on the same basis as a Physician. The fact that a Provider is described as a Physician does not mean that Benefits for services from that Provider are available to you under the Plan.

Physician Assistant - medical providers who are licensed to diagnose and treat illness and disease and to prescribe medication for patients. They work in physician offices, hospitals and clinics in collaboration with a licensed physician

Plan - the City of Austin Medical Plan.

Plan Administrator - the City of Austin or its designee.

Plan Sponsor - the City of Austin.

Preauthorization or Prior Authorization - a determination by the Blue Cross Blue Shield of Texas that health care services proposed to be provided to a patient are Medically Necessary and appropriate.

Pregnancy - includes all of the following:

1. Prenatal care.
2. Postnatal care.
3. Childbirth.
4. Any complications associated with the above.

Primary Care Physician (PCP) - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in a hospital setting when any of the following are true:

1. No skilled services are identified.
2. Skilled nursing resources are available in the facility.
3. The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
4. The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on a home-care basis, whether the service is skilled or non-skilled independent nursing.

Provider - an individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Procedure - a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Referral - specific directions or instructions from your PCP, in conformance with Blue Cross Blue Shield of Texas's policies and procedures that direct you to a Participating Provider for Medically Necessary care.

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance-Related and Addictive Disorders Services treatment. The facility meets all of the following requirements:

1. It is established and operated in accordance with applicable state law for Residential Treatment programs.
2. It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Administrator.
3. It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
4. It provides at least the following basic services in a 24-hour per day, structured milieu:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Retiree - an Employee who retires.

Semi-Private Room - a room with two or more beds. When an Inpatient Stay in a Semi-Private Room is a Covered Health Service, the difference in cost between a Semi-Private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-Private Room is not available.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Plan Document includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care - skilled nursing, teaching, and rehabilitation services when:

1. They are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient.
2. A Physician orders them.
3. They are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
4. They require clinical training in order to be delivered safely and effectively.
5. They are not Custodial Care, as defined in this section.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Spinal Treatment - detection or correction (by manual or mechanical means) of subluxation(s) in the body to remove nerve interference or its effects. The interference must be the result of, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse - an individual to whom you are legally married.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Surviving Dependent - an individual, previously covered under a deceased Retiree, who meets the criteria established by the Employer in order to be eligible for continued coverage under this Plan.

Telehealth Service - a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health care professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

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

Tier 1 Provider - a provider designated as providing higher quality of care and cost efficiency.

Transitional Living - Mental Health Services/Substance-Related and Addictive Disorders Services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

1. Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
2. Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Services - health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

Urgent Care - care that requires prompt attention to avoid adverse consequences but does not pose an immediate threat to a person's life. Urgent care is usually delivered in a walk-in setting and without an appointment. Urgent care facilities are a location, distinct from a hospital emergency department, an office or a clinic. The purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Virtual Visits - Virtual Visits provide you with access to Virtual Network Providers that can provide diagnosis and treatment of non-emergency medical and behavioral health conditions in situations that can be handled without a traditional PCP office visit, behavioral health office visit, Urgent Care visit, or Emergency Care visit. Covered Services may be provided via a consultation with a licensed medical professional through interactive audio via telephone or

interactive audio-video via online portal or mobile application. For information on accessing this service, you may access the website at **www.bcbstx.com/coa** or contact the free number on the back of your ID card. A PCP Referral is not required to obtain Covered Services.

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

Well Being Management - programs provided by Blue Cross Blue Shield of Texas that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

SECTION 14: OUTPATIENT PRESCRIPTION DRUGS

IDENTIFICATION CARD (ID CARD) – NETWORK PHARMACY

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by Blue Cross Blue Shield of Texas during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy and then file a claim for reimbursement.

COVERED DRUGS

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

1. Has been approved by the FDA for at least one indication.
2. Is recognized by the following for treatment of the indication for which the drug is prescribed:
    - A prescription drug reference compendium approved by the appropriate state agency.
    - Substantially accepted peer-reviewed medical literature.

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

Injectable Drugs

Injectable drugs approved by the FDA for self-administration are covered under the Plan. Benefits will not be provided under **Pharmacy Benefits** section for any self-administered drugs dispensed or administered by a Physician. You are responsible for any Deductibles, Copayment Amounts, Coinsurance Amounts, and pricing differences that may apply to the Covered Drug dispensed.

Diabetes Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of Diabetes Supplies for which a Physician or authorized Health Care Practitioner has written an order. Such Diabetes Supplies, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the ***Benefits for Treatment of Diabetes*** section of the medical portion of this Plan Document), shall include but not be limited to the following:

1. Test strips specified for use with a corresponding blood glucose monitor.
2. Lancets and lancet devices.
3. Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein.
4. Insulin and insulin analog preparations.
5. Injection aids, including devices used to assist with insulin injection and needleless systems.

6. Insulin syringes.
7. Biohazard disposable containers.
8. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels.
9. Glucagon emergency kits.

A separate Copayment Amount will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes at retail. Diabetic bundling is available using mail order. Members may receive insulin or oral agents and supplies at the insulin copay as long as insulin or oral agent is dispensed first and on the same day.

Preventive Care

Drugs (including both prescription and over-the-counter drugs) prescribed by a Health Care Practitioner which have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") (to be implemented in the quantities and within the time period allowed under applicable law) or as required by state law will be covered and will not be subject to any Copayment Amount, Coinsurance, Deductible or dollar maximum when obtained from a Participating Pharmacy.

Select Vaccinations Obtained through Participating Pharmacies

Benefits for select vaccinations, as shown on your *Schedule of Benefits*, are available through certain Participating Pharmacies that have contracted with Blue Cross Blue Shield of Texas to provide this service.

To locate one of these contracting Participating Pharmacies in the Pharmacy Vaccine Network in your area, and to determine which vaccinations are covered under this benefit, you may access our website at **www.bcbstx.com/coa** or call our Customer Service number shown in this Plan Document or on the back of your ID card. At the time you receive services, present your Blue Cross Blue Shield of Texas ID card to the pharmacist. This will identify you as a Participant in the Blue Cross Blue Shield of Texas health care plan provided by your employer. The pharmacist will inform you of the appropriate Copayment Amount, if any.

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

Childhood immunizations subject to state regulations are not available under these Pharmacy Benefits. Refer to your Blue Cross Blue Shield of Texas medical coverage for benefits available for childhood immunizations.

Formulas for the Treatment of Phenylketonuria or Other Heritable Diseases

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

Specialty Drugs

Benefits are available for Specialty Drugs. Specialty Drugs are generally prescribed to treat a chronic complex medical condition. They often require careful adherence to treatment plans and have special handling and storage requirements. You must obtain these drugs from the Specialty Pharmacy Program (see ***Specialty Pharmacy Program*** below.) In order to receive the highest level of benefits, use a Specialty Pharmacy Provider to obtain Specialty Drugs.

Proton Pump Inhibitors

Benefits are available for Generic, Preferred Brand and Non-Preferred Brand Name Drug proton pump inhibitors.

SELECTING A PHARMACY

Participating Pharmacy

When you go to a Participating Pharmacy:

1. Present your ID card to the pharmacist along with your Prescription Order.
2. Provide the pharmacist with the birth date and relationship of the patient
3. Sign the insurance claim log.
4. Pay the appropriate Copayment Amount for each Prescription Order filled or refilled.

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

1. The billed charges.
2. The Allowable Amount as determined by Blue Cross Blue Shield of Texas.
3. Other contractually determined payment amounts.

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

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access our website at **www.bcbstx.com/coa** or contact the Customer Service telephone number shown in this Plan Document or on the back of your ID card.

Non-Participating Pharmacy

If you have a Prescription Order filled at a Non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill. Benefits are not available for Covered Drugs, services or supplies received from a Non-Participating Pharmacy.

Mail-Order Program

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

Some drugs may not be available through the mail-order program. If you have any questions about this mail-order program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at

www.bcbstx.com/coa or contact Customer Service at the number on the back of your ID card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

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

Specialty Pharmacy Program

This program provides delivery of medications from the Specialty Pharmacy Provider directly to your Health Care Practitioner, administration location or to the home of the Participant.

Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Program. However, the first fill of your Specialty Drug Prescription Order may be obtained through a retail Pharmacy to allow you time to become established under the Specialty Pharmacy Program.

In order to receive the highest level of benefits, use a Specialty Pharmacy Provider to obtain Specialty Drugs. The Specialty Pharmacy Program delivery service offers:

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

If you and your covered Dependents use the Specialty Pharmacy Program, you should contact Customer Service at the number shown in this Plan Document or on the back of your ID card for information about how to submit your Prescription Orders.

You will also be given information on how to make payment for your share of the cost. A list identifying these Specialty Drugs is available by accessing the website at **www.bcbstx.com/coa** or by contacting Customer Service at the number on the back of your ID card. Your cost will be the appropriate Copayment Amount indicated on the *Schedule of Benefits*. You will also be responsible for any Deductible amounts that may apply to your coverage.

Step Therapy

Coverage for certain designated prescription drugs or drug classes may be subject to a step therapy program. Step therapy programs favor the use of clinically acceptable alternative medications before requested agent may be covered.

When you submit a Prescription Order to a Participating Pharmacy or through the mail service prescription drug program or through Providers that supply Preferred Specialty Drugs for one of

these designated medications, the Pharmacist will be alerted if the online review of your prescription claims history indicates an acceptable alternative medication that has not been previously tried. A list of step therapy medications is available to you and your Health Care Practitioner on our website at **www.bcbstx.com/coa**.

If it is Medically Necessary, coverage can be obtained for the prescription drugs subject to the Step Therapy Program without trying an alternative medication first. In this case, your Health Care Practitioner must contact Blue Cross Blue Shield of Texas to obtain an exception for coverage of such drug. If authorization is granted, the Participant and the Health Care Practitioner will be notified, and the medication will then be covered at the applicable Copayment Amount or Coinsurance Amount.

Step Therapy for Opioid Prescriptions

A patient should receive a prescription for a short-acting pain relief drug before initiating treatment with a long-acting opioid. Additionally, Blue Cross Blue Shield of Texas has chosen a long-acting opioid with abuse deterrent technology for its preferred product. If a prescriber has prescribed another product, such as Oxycontin or its generic, please understand this may delay the filling of the prescription. The patient can receive the nonpreferred long-acting opioid product with a Prior Authorization received from the physician.

Opioid Naïve Patient

Patients who have not received an opioid in the last 60 days are considered “opioid naïve.” Physicians prescribing a short-acting opioid to an opioid naïve patient should prescribe an amount equal to 7 days or less in duration. Prescriptions for longer duration may delay the patient receiving the prescription. A physician may request a prior authorization for opioid naïve patients needing an initial duration greater than 7 days. Once a patient has received a prescription for opioids in the last 60 days, they would be considered opioid experienced, and would not be limited by a seven-day supply.

Patients on high doses of Opioids

Patient receiving one or more opioids are at greater risk of receiving potentially harmful amounts of opioids in their system. Patients receiving doses that are equal to or greater than 200 Morphine Equivalent Dosing (MEDs) may require physician discussion for approval. Additional documentation may be needed.

YOUR COST

Pharmacy Deductible

The individual Deductible amount shown under Pharmacy Benefits on your *Schedule of Benefits* must be satisfied by each Participant under your coverage each Calendar Year. After the Deductible is met, the Participant will pay the appropriate Copayment Amount.

Whether you use a Participating Pharmacy through the mail service pharmacy or a Provider that supplies Preferred Specialty Drugs, the Allowable Amount of your Covered Drug expenses will be applied toward satisfaction of your Deductible.

Copayment Amounts

Copayment Amounts for a Participating Pharmacy, the mail-order program or a Provider that supplies Preferred Specialty Drugs are shown on your *Schedule of Benefits*. The amount you pay depends on the Covered Drug dispensed.

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

How Participant Payment is Determined

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

1. Tier 1 includes Generic Drugs.
2. Tier 2 includes Preferred Brand Name Drugs.
3. Tier 3 includes Non-Preferred Brand Name Drugs.

Any Deductible, Copayment Amount or Coinsurance Amount for Covered Drugs on each drug tier is shown on your *Schedule of Benefits*. You can also contact Customer Service at the number on the back of your ID card.

ABOUT YOUR BENEFITS

Drug List

The Drug List is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other Pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.
Blue Cross Blue Shield of Texas will routinely review the Drug List and periodically adjust it to modify the status of existing or new drugs. Changes to this list will occur as frequently as quarterly. The Drug List and any modifications will be made available to Participants. Participants may access our website at **www.bcbstx.com/coa** or call the Customer Service at the number shown in this Plan Document or on the back of your ID card to determine if a particular drug is on the Drug List. Drugs that do not appear on the Basic Drug List may be subject to the Non- Preferred Brand Name Drug Copayment Amount.

Day Supply

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

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

Dispensing Quantity Versus Time Limits

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

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

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

Prior Authorizations

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

When you submit a Prescription Order to a Participating Pharmacy or through the mail service prescription drug program or through Providers that supply Preferred Specialty Drugs for one of these designated medications, the Pharmacist will be alerted online if your Prescription Order is on the list of medication which requires prior authorization before it can be filled. If this occurs, your Health Care Practitioner will be required to submit an authorization form. This form may also be submitted by your Health Care Practitioner in advance of the request to the Pharmacy. The

Health Care Practitioner can obtain the authorization form by accessing our website at Blue Cross Blue Shield of Texas. The requested medication may be approved or denied for coverage under the Plan based upon its accordance with established clinical criteria.

Controlled Substances Limitations

If it is determined that a Participant may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to review to assess whether Medically Necessary or appropriate and restrictions may include but not be limited to a certain Provider and/or Pharmacy of the Participant's choice and/or quantities and/or days' supply for the prescribing and dispensing of the controlled substance medication. If the Participant does not choose such Provider and/or Pharmacy within a reasonable time, Blue Cross Blue Shield of Texas will make the choice. Additional Copayment Amounts, Coinsurance Amounts, and any Deductible may apply.

Right of Appeal

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

LIMITATIONS AND EXCLUSIONS

Pharmacy benefits are not available for:

1. Drugs which do not by law require a Prescription Order, except as indicated under ***Preventive Care*** in **Pharmacy Benefits**, from a Provider or authorized Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and select vaccinations administered through certain Participating Pharmacies as shown on your *Schedule of Benefits*); and Legend Drugs or covered devices for which no valid Prescription Order is obtained.
2. Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia National Formulary), including, but not limited to preservatives, solvents, ointment bases and flavoring coloring diluting emulsifying and suspending agents.
3. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order) such as, but not limited to therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies shall be specific exceptions to this exclusion.) NOTE: Coverage for the rental or purchase of a manual, electric, or Hospital grade breast pump and female contraceptive devices is provided as indicated under the medical portion of this Plan.
4. Administration or injection of any drugs.

5. Vitamins (except those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative or as indicated under ***Preventive Care*** in Pharmacy Benefits.)
6. Drugs injected, ingested or applied in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
7. Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
8. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
9. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Select Vaccinations administered through Participating Pharmacies are an exception to this exclusion.
10. Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.
11. Non-prescription contraceptive materials, (except prescription contraceptive drugs which are Legend Drugs. Contraceptive drugs provided by a Participating Pharmacy will not be subject to Coinsurance Amounts, Deductibles, Copayment Amounts and/or dollar maximums as shown in ***Benefits for Preventive Care Services***.)
12. Any non-prescription contraceptive medications or devices for male use.
13. Infertility and fertility medications.
14. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, except as required by the Affordable Care Act.
15. Drugs required by law to be labeled: “Caution - Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made for the drugs.
16. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your *Schedule of Benefits*, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

17. Legend Drugs which are not approved by the FDA for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
18. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exclusion does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
19. Any drugs provided for reduction of obesity or weight, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight.
20. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
21. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the ID card.
22. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under your Employer's group health care plan, or for which benefits have been exhausted.
23. Rogaine, minoxidil, or any other drugs, medications, solutions, or preparations used or intended for use in the treatment of hair loss, hair thinning, or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
24. Compounded drugs that do not meet the definition of Compound Medications in this portion of your Plan Document.
25. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
26. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the Plan.
27. Retin A or pharmacologically similar topical drugs over age 40.
28. Athletic performance enhancement drugs.
29. Bulk powders.
30. Surgical supplies.
31. Ostomy products.
32. Diagnostic agents. This exclusion does not apply to diabetic test strips.
33. Drugs used for general anesthesia.
34. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
35. Allergy testing materials.
36. Injectable drugs, except self-administered Specialty Drugs or those approved by the FDA for self-administration.
37. Self-administered drugs dispensed or administered by a Physician in his/her office.
38. Prescription Orders which do not meet the required Prior Authorization criteria.
39. Some drugs are manufactured under multiple names and have many

40. therapeutic equivalents. In such cases, Blue Cross Blue Shield of Texas may limit benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under your Plan, the drug purchased will not be covered under any benefit level.
41. Specialty Drugs, unless obtained through the ***Specialty Pharmacy Program***.
42. Specialty Drugs obtained from a retail Pharmacy in excess of the first fill as described in ***Specialty Pharmacy Program.***
43. Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced. (One exception per Calendar Year.)
44. Shipping, handling or delivery charges.
45. Institutional packs and drugs that are repackaged by anyone other than the original manufacturer.
46. Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.
47. Nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant.
48. Drugs determined by the Plan to have inferior efficacy or significant safety issues.
49. Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

DEFINITIONS

In addition to the applicable terms provided in the *Definitions* section of the Plan Document, the following terms will apply specifically to this Pharmacy Benefits section.

Allowable Amount - the maximum amount determined by the Blue Cross Blue Shield of Texas to be eligible for consideration of payment for a particular Covered Drug. As applied to Participating Pharmacies, the mail-order program and Providers that supply Preferred Specialty Drugs, the Allowable Amount is based on the provisions of the contract between Blue Cross Blue Shield of Texas and the Participating Pharmacy or Pharmacy for the mail-order program or the Provider that supplies Preferred Specialty Drugs in effect on the date of service.

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

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

1. The drugs in the compounded product are Food and Drug Administration

(FDA) approved.
2. The approved product has an assigned National Drug Code (NDC.)
3. The primary active ingredient is a Covered Drug under the Plan.

Controlled Substance - an abusable volatile chemical as defined in the Texas Health and Safety Code, or a substance designated as a Controlled Substance in the Texas Health and Safety Code.

Copayment Amount - the dollar amount paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy.

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

1. Which is Medically Necessary and is ordered by an authorized Health Care Practitioner naming a Participant as the recipient.
2. For which a written or verbal Prescription Order is provided by an authorized Health Care Practitioner.
3. For which a separate charge is customarily made.
4. Which is not consumed at the time and place that the Prescription Order is written.
5. For which the FDA has given approval for at least one indication.
6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Plan, except when received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (refer to **Limitations and Exclusions**.)

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

Drug List - a list of drugs that may be covered under the **Pharmacy Benefits p**ortion of the Plan. This list is available by accessing the website at **www.bcbstx.com/coa.** You may also contact Customer Service at the number on the back of your ID card for more information. Changes to this list will be implemented on the Employer's Contract Anniversary Date. The Drug List and any modifications will be made available to Participants.

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

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

Legend Drugs - drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing without a Prescription," and which are approved by the FDA for a particular use or purpose.

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

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

Participant (Member) - an Employee, Dependent, or a Retiree whose coverage has become effective under this Plan.

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

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

Pharmacy Vaccine Network - the network of select Participating Pharmacies which have a written agreement with Blue Cross Blue Shield of Texas to provide certain vaccinations to Participants under this Plan.

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

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

Select Participating Pharmacy - a Pharmacy that has specifically contracted with Blue Cross Blue Shield of Texas to administer vaccinations to Participants. Not all Participating Pharmacies are Select Participating Pharmacies.

Specialty Drug - specialty medication that are used to treat complex medical conditions and are typically given by injection but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies.

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

Specialty Pharmacy Provider - a Participating Pharmacy which has entered into a written agreement with Blue Cross Blue Shield of Texas to provide Specialty Drugs to Participants under the Plan.

Tier - a category that Covered Drugs are placed into.

SECTION 15 - IMPORTANT BENEFITS INFORMATION AND NOTICES

ATTACHMENT I - HEALTH CARE REFORM NOTICES

PATIENT PROTECTION AND AFFORDABLE CARE ACT ("PPACA")

Patient Protection Notices

Blue Cross Blue Shield of Texas generally allows the designation of a primary care Provider. You have the right to designate any primary care Provider who participates in Blue Cross Blue Shield of Texas's network and who is available to accept you or your family members. For information on how to select a primary care Provider, and for a list of the participating primary care Providers, contact Customer Service at the number on the back of your ID card. For children, you may designate a pediatrician as the primary care Provider.

You do not need prior authorization from Blue Cross Blue Shield of Texas or from any other person (including a primary care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in Blue Cross Blue Shield of Texas's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Blue Cross Blue Shield of Texas at the number on the back of your ID card.

Notice to Enrollees in a self-funded nonfederal governmental group health plan for plan years beginning on or after September 23, 2010

Group Health plans sponsored by State and local governmental employers must generally comply with Federal law requirements in title XXVII of the Public Health Service Act. However, employers are permitted to elect to exempt a plan from the requirements listed below for any part of the plan that is “self-funded” by the employer, rather than provided through a health insurance policy. The City of Austin has elected to exempt the City’s medical plans of the following requirements:

1. Parity in the application of certain limits to mental health benefits. Limit coverage for Applied Behavior Analysis treatment to 170 visits each year for individuals diagnosed with autism.
2. The exemption from these Federal requirements will be in effect for the 2020 plan year beginning January 1, 2020 and ending December 31, 2020. The election will be renewed for subsequent plan years.

Affordable Care Act Excise Tax

As part of the Patient Protection and Affordable Care Act (Health Reform) effective January 2022, medical plans which exceed a threshold level established by the federal government will have to pay a 40% excise tax. The City of Austin is committed to designing a medical plan that is below the threshold level. However, if the threshold is reached, the cost of the excise tax will be passed on to Employees and Retirees.

HIPAA Notice of Privacy Practices
A group health plan (or an insurer) subject to the HIPAA privacy rules must provide this notice describing the uses and disclosures of protected health information (PHI) and the individual's rights and the plan's (or insurer's) duties with respect to that PHI. The model notice can be found at **www.austintexas.gov/benefits**.

THE NEW HEALTH INSURANCE MARKETPLACE, COVERAGE OPTIONS AND YOUR CITY HEALTH COVERAGE

PART A: General Information
The Health Insurance Marketplace is a new way to purchase health insurance in the United States. As you evaluate health insurance options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your Employer, the City of Austin.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
Regular full-time Employees will not experience savings because the City pays the entire premium for the CDHP and the majority of the PPO and HMO premium. Part-time Employees may realize savings by going to the Marketplace.

Temporary Employees with less than 12 months of service are not eligible for City-provided medical coverage. Temporary Employees and their dependents can purchase health insurance through the Health Insurance Marketplace, designed to provide affordable health insurance.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. The City of Austin offers coverage that meets government standards. If you are in a regular budgeted position and work full-time, you will not be eligible for a tax credit at the Marketplace.

If you are in a regular budgeted position working part-time, and the premium you would pay for the City's lowest cost medical plan (Employee Only) is more than 9.5% of your household income for the year, you may be eligible for a tax credit at the Marketplace. If you are a Temporary Employee, and therefore not eligible for medical coverage under a City medical plan, you are eligible for medical coverage through the Marketplace and may also qualify for a tax credit.
Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by the City of Austin, then you may lose the City's contribution (if any) to the

Employer-offered coverage. Also, the City's contribution as well as your Employee contribution to City offered coverage is usually excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by the City of Austin, review this guide, or go to **www.austintexas.gov/benefits** for your summary plan description, or contact City of Austin at 512-974-3284.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.healthcare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by the City
This section contains information about health coverage offered by the City of Austin. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<tr><td colspan="2">3. Employer name: City of Austin</td><td>4. Employer Identification Number: 74-6000085</td></tr>
<tr><td colspan="2">5. Employer address: P.O. Box 1088</td><td>6. Employer phone number: 1-512-974-3284</td></tr>
<tr><td>7. City: Austin</td><td>8. State: Texas</td><td>9. ZIP code: 78767</td></tr>
<tr><td colspan="3">10. Who can we contact about Employee health coverage at this job?
Human Resources Department, Employee Benefits Division</td></tr>
<tr><td colspan="2">11. Phone number: 1-512-974-3284</td><td>12. Email address: HRD.Benefits@austintexas.gov</td></tr>
</table>

Basic Health Care Coverage Information
As your Employer, the City of Austin offers a health plan to all Employees in regular budgeted positions and to temporary Employees with more than 12 months of continuous service.

The City of Austin offers Dependent coverage to eligible Dependents. Eligible Dependents (Spouse, Domestic Partner, children, Dependent grandchildren) are detailed in this Plan document.

The City's coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on Employee wages.

Note: Even though the City of Austin offers affordable coverage, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If you are an hourly Employee, or have previously been unemployed, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **www.healthcare.gov** will guide you through the process.

ATTACHMENT II - LEGAL NOTICES

THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)
This act imposes the following restrictions on group health plans:

Limitations on pre-existing exclusion periods. Pre-existing conditions can only apply to conditions for which medical advice, diagnosis, care, or treatment was recommended or received during a period beginning six months prior to an individual's enrollment date, and any pre-existing condition exclusion is not permitted to extend for more than 12 months after the enrollment date. Further, a pre-existing condition exclusion period may be reduced by any creditable previous coverage the individual may have had.

Special enrollment. Group health plans must allow certain individuals to enroll upon the occurrence of certain events, including new dependents and loss of other coverage. Loss of coverage includes:

1. Termination of employer contributions toward other coverage
2. Moving out of an HMO service area
3. Ceasing to be a "dependent," as defined by the other plan
4. Loss of coverage to a class of similarly situated individuals under the other plan (i.e., part-time Employees)

Additionally, individuals entitled to special enrollment must be allowed to enroll in all available benefit package options and to switch to another option if he or she has a Spouse or Dependent with special enrollment rights.

Prohibitions against discriminating against individual participants and beneficiaries based on health status. Plans may not establish rules for eligibility of any individual to enroll under the terms of the plan based on certain health status-related factors, including health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability.

Standards relating to benefits for mothers and newborns. Plans must provide for a 48-hour minimum stay for vaginal childbirth, and a 96-hour minimum stay for cesarean childbirth, unless the mother or medical provider shortens this period. No inducements or penalties can be used with the mother or medical provider to circumvent these rules.

Parity in the application of certain limits to mental health benefits: Plans must apply the same annual and lifetime limits (i.e., dollar amounts) that apply to other medical benefits to benefits for mental health. If this requirement results in a 1% or more increase in plan costs or premiums, this rule does not apply.

YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Beneficiary Creditable Coverage Disclosure Notice

This notice has information about your current prescription drug coverage with the City of Austin and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining a Medicare drug plan, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in this area. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. On January 1, 2006, new prescription drug coverage became available to individuals with Medicare Part A. This coverage is available through Medicare prescription drug plans, also referred to as Medicare Part D. All such plans provide a standard, minimum level of coverage established by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Austin has determined that prescription drug coverage offered through City health plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Other Important Considerations

1. If you currently have prescription drug coverage through a City health plan, you may choose to enroll in Medicare Part D annually between October 15 and December 7, or when you first become eligible for Medicare Part D.
2. If you decide to join a Medicare drug plan, your current City of Austin medical coverage will not be affected.
3. If you do decide to join a Medicare drug plan and drop your current City of Austin coverage for your dependents, you may be able to get this coverage back during an Open Enrollment period.
4. You should also know that if you drop or lose your current coverage with the City of Austin and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium.
5. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.
6. If you are enrolled in Medicare Part D or a Medicare Advantage Plan and are also enrolled in the City health plan, you may have duplicate prescription coverage. If you

would like to review your coverage or for more information, contact the Employee Benefits Division of the Human Resources Department at 1-512-974-3284.

More information about Medicare Part D prescription drug coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the *Medicare & You* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. You can also:

1. Visit **www.medicare.gov** for personalized help.
2. Call the **Health and Human Services Commission of Texas** at 1-888-834-7406, local number 1-800-252-9330.
3. Call 1-800-MEDICARE (1-800-633-4227.)
4. TTY users should call 1-877-486-2048.

Financial assistance may be available for individuals with limited income and resources through the **Social Security Administration (SSA.)** For more information, visit the SSA website at **www.socialsecurity.gov** or call 1-800-772-1213. TTY users should call 1-800-325-0778.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your Employer plan, your Employer must allow you to enroll in your Employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

You may be eligible for assistance paying your Employer health plan premiums. The following is current as of January 31, 2020. Contact your State for more information on eligibility.

TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact:

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998
As required by the *Women's Health and Cancer Rights Act of 1998*, the Plan provides Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema.)

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

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

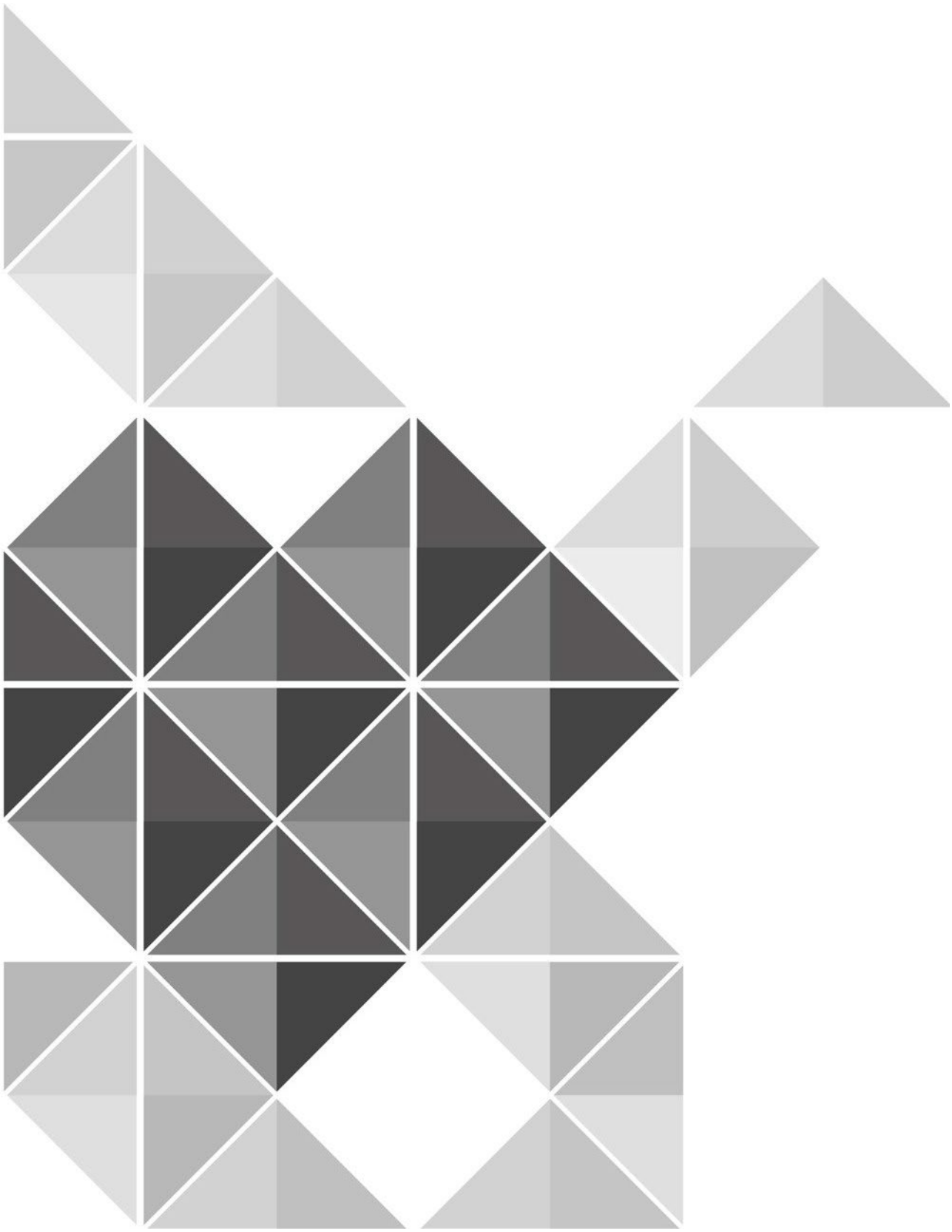
The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHER'S HEALTH PROTECTION ACT
Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending Provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours.) However, to use certain Providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain prior authorization or notify Blue Cross Blue Shield of Texas. For information on notification or prior authorization, contact your issuer.

Administered by: **BlueCross BlueShield of Texas**



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