2021
2022

Blue Choice PPO℠ Medical Plan Book

TML Health Benefits Pool

Benefit coverage provided by TML Health. Claims administered by Blue Cross and Blue Shield of Texas.

TABLE OF CONTENTS

FOREWORD

TML Health Benefits Pool (TML Health) has prepared this booklet to help you understand the medical benefits provided through your Employer. The Medical Plan (the Plan) described in this booklet provides coverage for a wide range of medical care, services, and supplies. However, your benefits are affected by certain limitations and conditions that require you to be an informed consumer of health services and to use only those services you need. Benefits are not provided for non-medically evidence-based treatment or ineligible services, even if recommended by your Physician. Please review the Medical Limitations and Exclusions section and the Preauthorization section. TML Health urges you to familiarize yourself with the provisions in the Plan description in order to understand your Benefits. TML Health is encouraging all members to review the Medical Plan Booklet and engage in their health. There is a glossary of healthcare definitions in the back of the book to assist you with your understanding of healthcare services.

Disclaimer: *A new benefit booklet is distributed at the beginning of the Plan Year. Please verify the date referenced on the front cover of the Medical Plan Book to make sure you are referring to the medical Benefits that coordinate with the Incurred service date.*

Group Benefit Medical Plan for TML Health*

This notice certifies that TML Health has accepted your Employer as a risk-participating member of TML Health. Your Employer has selected a Plan of Benefits and may have the responsibility for compliance with state and federal laws applicable to employee benefits. However, for most state and federal laws applicable to a health plan based upon the number of Employees enrolled or eligible to enroll in the health plan, the size of the health plan is determined by the number of individuals enrolled in TML Health as a whole and not based on any one Employer's number of Employees. This is a governmental plan excluded from coverage under ERISA (29 U.S.C.A. 1003(b)).

The Plan covers Actively-At-Work Employees, Dependents of Actively-At-Work Employees, elected officials, Dependents of elected officials, pre sixty-five Retirees, and Dependents of pre sixty-five Retirees of Pool Members who are eligible for coverage, become covered, and continue to be covered according to the terms of the Plan, Pool policies, and of the Employer's medical Benefits. In case of a conflict between a TML Health plan provision, policy rule, regulation, or underwriting guideline and Employer coverage, the TML Health plan provision, policy rule, regulation, or underwriting guideline shall override the Employer coverage in deciding whether an individual is eligible for coverage or whether a Benefit should be paid. The Board of Trustees of TML Health reserves the right to amend the Plan if circumstances warrant and has given the Executive Director the discretionary authority to construe the terms of the Plan.

** A risk pool created under and governed by the Texas Political Subdivisions Uniform Group Benefits Program (Chapter 172 Texas Local Government Code). Section 172.014 of that chapter provides that "A risk pool created under this Section is not insurance or an insurer under the Insurance Code or other laws of this state, and the State Board of Insurance [now the Texas Department of Insurance] does not have jurisdiction over a pool created under this Section."*

Notice to Plan Participants regarding TML Health Election under 42 U.S.C. § 300gg-21

Chapter 172 Group health plans are regulated by federal laws named the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Healthcare and Education Reconciliation Act of 2010. Generally, a group health plan must comply with the requirements of those laws that are listed below. However, the law permits State and local governmental health plans to elect to exempt the plan from these requirements if that plan is self-funded rather than provided through a health insurance policy. TML Health has elected to exempt the Plan from the following requirements:

1. Standards relating to Benefits for mothers and newborns. A health plan may not restrict Benefits for a Hospital stay for the birth of a Child to less than forty-eight (48) hours for a vaginal delivery and ninety-six (96) hours for a cesarean section;
2. Parity in Mental Health or Substance Use Disorders. A health plan that covers Treatment for medical and surgical disorders as well as for Mental Health and Substance Use Disorders may not place a more restrictive limit on the dollar value or number of Treatments that are available for Mental Health or Substance Use Disorders than are available for medical and surgical disorders;

3. Required coverage for Reconstructive Surgery following mastectomy. A health plan that provides medical and surgical Benefits for mastectomy must provide certain Benefits for breast reconstruction as well as for certain other related services; and
4. Coverage of Dependent students on Medically Necessary leave of absence. A health plan must allow a covered Dependent Child, whose eligibility for coverage is based on student status, to continue coverage for up to one (1) year while on a Medically Necessary leave of absence from a postsecondary educational institution.

Because of this election:

1. The duration of a Hospital Confinement for a mother and newborn following the birth of a Child will be determined based on eligibility.
2. Benefits for serious mental illness as defined by Texas law are treated as any other covered medical or surgical condition.
3. The Plan pays for evidence-based initial mastectomy/lumpectomy and reconstructive oncology surgery of affected and non-affected breast. Eligible Benefits include the initial non-cosmetic removal and replacement of prosthetics due to complications. Reconstructive Surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.
4. TML Health does not determine a Dependent Child's eligibility based on student status. Therefore, TML Health does not extend coverage for students on a Medically Necessary leave of absence.

In addition to the above, on April 14, 2003, the Federal government imposed HIPAA Title II which pertains to administrative simplification of health plans. The administrative simplification process includes: standards for electronic transactions and code sets, national identifiers for employers, health plans, and Healthcare Providers, security standards for the protection of health information (Security Rule), standards for notification in case of breach of unsecured health information, and standards for privacy of individually identifiable health information (Privacy Rule). A self-funded, non-federal, governmental health plan cannot exempt itself from any of the requirements of HIPAA Title II.

The intent of TML Health with regard to the Plan is to provide coverage that is compliant with applicable State and Federal laws and regulations, including mid-plan year changes when mandated by law

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your healthcare expenses for Medically Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affect your healthcare coverage. Changes in state or federal law or regulations, or interpretation thereof, may change the terms and conditions of coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Benefit Program Application provided to your Employer by BCBSTX prevails.

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

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

In-Network Benefits

To receive In-Network Benefits as indicated on your SBC, you must choose Providers within the Network for all care (other than for emergencies). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other healthcare facilities to serve Participants throughout the Network Plan Service Area.

Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually or you may access, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

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

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

1. The billed charges, or
2. The Allowable Amount as determined by BCBSTX, or
3. Other contractually determined payment amounts.

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

Out-of-Network Benefits

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

You will be responsible for.

1. Billed charges above the Allowable Amount as determined by BCBSTX,
2. Coinsurance Amounts and Deductibles,
3. Preauthorization, and
4. Limited or non-covered services.

Important Contact Information

Questions about...	Access	Contact Info	Hours
• Medical benefits • Medical procedures • Major imaging like MRI, CT, etc. - *Call before your appointment* • Cost estimates for procedures • Medical claims, EOBs • Select or change PCP • Deductibles, co-payments, coinsurance	Blue Cross and Blue Shield of Texas Helpline	855-762-6084	24 hours a day 7 days a week
• Enrolling in benefits • Adding, removing, or changing any TML Health administered benefit • Changing your contact information • Spending accounts, including balances • Life insurance • TML Health website • TML Health Online password reset • General questions	TML Health Member Service	800-282-5385	Monday-Friday 7:00 am-6:00 pm CT
• Prescription drugs covered by the plan • Rx Copays and lower cost options • Mail-order pharmacy • Specialty pharmacy • Pharmacy network • Prescription drug plan benefits	Navitus Customer Care	855-673-6504	24 hours a day 7 days a week
• Medical procedures requiring prior approval *(also known as a prior authorization)*	Medical Preauthorization Helpline	800-441-9188	Monday-Friday 6:00 am-6:00 pm CT
• Mental health prior authorization • Substance use prior authorization	Mental Health/Chemical Dependency (SUD) Preauthorization Helpline	800-528-7264	24 hours a day 7 days a week
• TML Health Online access • Access to benefits books • Health and wellness resources	TML Health Website	www.tmlhb.org	24 hours a day 7 days a week
• Blue Access for Members (BAM) • Find an In-Network provider	BCBSTX Website	www.BCBSTX.com	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

1. Identify your Plan Service Area
2. Give you information about Network and ParPlan and other Providers contracting with BCBSTX
3. Answer your questions on claims
4. Assist you in finding In-Network doctors, providers and hospital to help avoid Out-of-Network costs
5. Provide information on the features of the Plans, maximize and navigate benefits
6. Record comments about Providers
7. Assist you with questions regarding Physician after-hours access
8. Help you better understand your benefits
9. Give you a cost estimate for healthcare services and procedures
10. Assist you with comparing costs at different providers near you
11. Schedule a doctor or procedure appointment
12. Help you get general health information about your condition
13. Help you with preauthorization (if needed)
14. Tell you about online educational tools
15. Connect you to our 24/7 Nurseline

Customer Service can also assist you with special communications needs. If your first language is not English, you can ask to speak to a bilingual staff member (English or Spanish). Some written materials are available in Spanish through Customer Service. Members may also ask for access to a telephone based translation service to assist with other languages.

BCBSTX provides TDD/TTY services and language assistance for incoming callers for D/deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTYpewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator.

Benefits Value Advisor (BVA)

The Benefit Value Advisor (BVA) program has been established to assist you in maximizing your benefits under the Plan and lowering your out-of-pocket costs for Major Imaging Services. BVAs are specially-trained customer service representatives who assist you by comparing costs and providing information on Participating Providers for certain types of healthcare services. A BVA helps you navigate your benefits.

In addition to calling the BVA, you may have other call requirements. A call to a BVA does not satisfy any other call requirements you may have, including preauthorization requirements for MRI and CT Scan services.

A BVA may reach out to you about your preauthorized MRI or CT scan. To search for information about your Participating Provider options and estimate costs, contact a BVA directly at the number shown on the back of your identification card, logging into the Blue Access for Members Provider Finder tool online, or through the mobile application.

Mental Health/Chemical Dependency (SUD) Preauthorization Helpline

To satisfy Preauthorization requirements for Participants seeking treatment for Behavioral Health Services, you, your Behavioral Health Practitioner, or a family member may call the Mental Health/Chemical Dependency (SUD) Preauthorization Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical Preauthorization requirements, call the Medical Preauthorization Helpline on the back of your ID card.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The names, social security numbers, genders, and birth dates of all persons in a family Enrolling in the Plan will be provided to us on an enrollment form or a change form signed and dated by you and your Employer and received by us. You may be required to submit supporting documentation to show your Dependents are eligible under the Plan.

If we do not receive the requested Dependent information within the designated eligibility timeline specified, but the Employer provides us with payroll documentation that Contributions were deducted from your paycheck appropriately, then we will Enroll the Dependent(s) per the payroll documentation.

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

Initial Enrollment (New Hire Enrollment)

To receive coverage, new hires and newly eligible Employees and their Dependents must Enroll in the Plan in a timely manner. We must receive enrollment within thirty-one (31) days of the date of hire or within thirty-one (31) days of the coverage effective date, whichever is later, regardless of whether the Employer has a Waiting Period or a waiting and orientation period. (If the Employer has 100% participation in the Plan and pays 100% of the Employee's cost of coverage, we will allow a thirty (30) day grace period for this rule.) If you are not Enrolled in a timely manner, you and any Dependents cannot be added to the Plan until the next Open Enrollment period, or a Qualifying Life Event occurs.

Upon timely enrollment, coverage will begin the later of:

1. The date you became an Actively-At-Work Employee working at least twenty (20) hours per week; or
2. The date you complete any Waiting Period established by your Employer.

Annual Open Enrollment

During the Open Enrollment period, you can make changes to your enrollment, such as adding or dropping Dependents. Changes made during Open Enrollment will become effective on the Plan's effective date. If the Open Enrollment information is not received by us within the Open Enrollment period, you and your Dependents may not be Enrolled.

Qualifying Life Events

A Qualifiying Life Event is a change in your situation – like getting married, having a baby, or losing other health coverage – that can make you eligible for a Special Enrollment Period, allowing you to Enroll in health benefits outside the annual Open Enrollment Period. Refer to IRS 26 CRF 1.125-4 – Permitted elections changes for a complete list.

Adding Dependent Coverage

When adding a newborn or newly adopted Child, you must make enrollment changes within sixty (60) days. The fact that you have other Dependent Children, or a Spouse covered does not automatically extend coverage to a newborn.

Coverage for a newborn child will be automatic for the first thirty-one (31) days following the birth of your newborn child. For coverage to continue beyond this time, you must notify us within sixty (60) days of the birth and pay any required contribution within the next billing cycle. Coverage will become effective on the date of birth. If we are notified after that sixty (60) day period, you must wait until the next Open Enrollment Period to Enroll the newborn child.

When adding Dependents due to loss of eligibility under Medicaid or a State Children's Health Insurance Program (SCHIP), you must make enrollment changes within sixty (60) days of loss of coverage.

For all other Qualifying Life Events, you must make enrollment changes within thirty-one (31) days of the Qualifying Life Event date (the date of the QLE). Coverage will become effective on the date of the Qualifying Life Event.

We will exempt the following Employees from the 100% participation requirement:

1. If you are hired to work for a political subdivision and can provide the Employer with documentation of Benefits from prior employment due to retirement;
2. You are accessing a parental healthcare plan to the attained age of twenty-six (26);
3. You choose to be covered under your Spouse's healthcare plan in place of our Plan;
4. You or your Spouse are accessing Veterans Administration (VA) or TRICARE (employer-provided financial incentive is disallowed);
5. You choose to be on a Medicare plan with NO financial incentive;
6. You access the coverage offered to tribal members;
7. You access another plan due to Full-Time Equivalency status with two employers (thirty (30) hours a week, one hundred thirty (130) hours a month, or one hundred twenty (120) seasonal days a year).

Retirement

If your Employer offers retiree coverage, we must receive your enrollment information within thirty-one (31) days of the commencement of your retirement. If you Enroll, coverage will begin the date you become a Retiree.

Upon retirement, if you Enroll in Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)*coverage, the Retiree Medical Benefit will not be an option at the termination of COBRA*.

Retiree Pool coverage is terminated upon Medicare eligibility at age sixty-five (65).

Active Duty Reservists

If covered by the Plan as an Employee at the time of call to active duty, active duty reservists or guard members and their covered Dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which absence begins is the Qualifying Event for COBRA* to be offered to you as a reservist or guard member.

If a firefighter or police officer is called to active duty for any period, the Employer must continue to maintain any health, dental, or life coverage received on the date the firefighter or police officer was called to active military duty until the Employer receives written instructions from the firefighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COBRA* purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance.

In administering this coverage, we will follow the time guidelines of COBRA* under 42 U.S.C.A. 300bb-1 et seq. To qualify for this coverage, you must give written notice to the Employer within sixty (60) days of the Qualifying Event. The Employer must notify us that an Employee has been called to active duty and submit a copy of the Employer's Active Reservist Policy.

Under USCA § 4316, an Employee who is called for military leave may have rights to COBRA* for up to twenty-four (24) months and a right to reemployment once he/she is discharged from active military service.

If you will be on active duty for thirty-one (31) days or less, the Employer will keep you on the Plan with no change in coverage. If you will be on active duty for more than thirty-one (31) days, the Employer will notify us of the Qualifying Event and submit a copy of your written order for call to duty.

If we administer COBRA*, the Employer must notify us by sending a Qualifying Event Notice and mark the Qualifying Event "Called to Active Duty" and attach a copy of your written order for the call to duty.

If the Employer administers their own COBRA*, the Employer must notify us of the termination if call to active duty is more than thirty-one (31) days. The Employer is responsible for all required notices.

Section 143.072, Texas Local Government Code may require an Employer to "continue to maintain" coverage on a police officer or firefighter while he/she is on military leave if the Employer has adopted civil service requirements and the leave has been approved by the Firefighters' and Police Officers' Civil Service Commission. This Section only applies if the Employer meets the requirements of Chapter 143 of that Code, including having a population of 10,000 or more and having voted to adopt the applicable provisions of the law.

For you, an individual nineteen (19) years of age or older, to return to the Employer's Plan and continue your Benefits with no Waiting Period, you must return to work as an Employee within the time period required by state and federal law for such return.

The additional 2% of Contributions is not charged for you when called to active duty.

** An Employee's right to COBRA coverage is subject to Federal law. Please see the COBRA Notice for more information.*

HOW THE PLAN WORKS

Allowable Amount

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

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

Case Management

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

1. You, your family, and the Physician agree;
2. Benefits are cost effective; and
3. BCBSTX anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

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

Continuity of Care

In the event you are under the care of a Network Provider at the time such Provider stops participating in the Network and at the time of the Network Provider's termination, you have special circumstances such as a (1) disability, (2) acute condition, (3) life-threatening illness, or (4) are past the 13th week of pregnancy and are receiving treatment in accordance with the dictates of medical prudence, BCBSTX will continue providing coverage for that Provider's services at the In-Network Benefit level.

Special circumstances means a condition such that the treating Physician or healthcare Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to you. Special circumstances shall be identified by the treating Physician or healthcare Provider, who must request that the you be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from you of any amounts for which you would not be responsible if the Physician or Provider were still a Network Provider.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if you have been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, if you are past the 13th week of pregnancy at the time the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

Freedom of Choice

Each time you need medical care you can choose to:
See an In-Network Provider
• You receive the higher level of benefits (In-Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the BCBSTX Allowable Amount for covered services • Your Provider will preauthorize necessary services
See an Out-of-Network Provider
ParPlan Provider (refer to ParPlan, below, for more information)
• You receive the lower level of benefits (Out-of-Network Benefits) • You are not required to file claim forms in most cases; ParPlan Providers will usually file claims for you • You are not balance billed; ParPlan Providers will not bill for costs exceeding the BCBSTX Allowable Amount for covered services • In most cases, ParPlan Providers will preauthorize necessary services
Out-of-Network Provider that is not a contracting Provider
• You receive Out-of-Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the BCBSTX Allowable Amount for covered services • You must preauthorize necessary services

Identification Card

Cards issued by the Claim Administrator to Participants under this Plan are for identification only. The Identification Card confers no right to services or other benefits under this Plan. To be entitled to any services or benefits, the holder of the Identification Card must be a Participant on whose behalf all applicable Contributions under this Plan have actually been paid. The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan with TML Health. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

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

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

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

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

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
    a. Use of the Identification Card prior to your Effective Date;
    b. Use of the Identification Card after your date of termination of coverage under the Plan;
    c. Obtaining benefits for persons not covered under the Plan;
    d. Obtaining benefits that are not covered under the Plan.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any covered individual can result in, but is not limited to, the following sanctions being applied to all individuals covered under your coverage:
    a. Denial of benefits;
    b. Cancellation of coverage under the Plan for all individuals under your coverage;
    c. Recoupment from you or any of your covered Dependents of any benefit payments made;
    d. Pre-approval of drug purchases and medical services for all individuals receiving benefits under your coverage;
    e. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary and Evidence Based as determined by BCBSTX. Charges for services and supplies which BCBSTX determines are not Medically Necessary or Evidence Based will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Out-of-Pocket Maximum.

ParPlan

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

1. File all claims for you,
2. Accept the BCBSTX Allowable Amount determination as payment for Medically Necessary services, and
3. Not bill you for services over the Allowable Amount determination. You will receive Out-of-Network Benefits and be responsible for:
4. Any Deductibles,
5. Coinsurance Amounts, and
6. Services that are limited or not covered under the Plan.

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

Specialty Care Providers

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

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

1. If the services you require are not available from Network Providers within a seventy-five (75) mile radius from the Employee’s home, In-Network Benefits subject to the out-of-network plan defined allowable amount will be provided when you use Out-of-Network Providers.

2. If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Benefits will be available.

Use of Non-Contracting Providers

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

PREAUTHORIZATION REQUIREMENTS

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the Preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits. Actual availability of benefits is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contribution, and eligibility at the time care and services are provided. For additional information and a current list of medical and healthcare services that require Preauthorization, please visit the website at www.bcbstx.com.

The following types of service require Preauthorization:

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. Outpatient transplant evaluations
9. Non-Emergency Fixed-Wing Air Ambulance transportation

Additional Outpatient Procedures/Services for

1. Cardiac (heart related)
    a. Cardiology
    b. Cardiac advanced imaging
    c. Stress testing (myocardial perfusion imaging - single-photon emission computed tomography SPECT and PET)
    d. Cardiac CT and MRI
    e. Echocardiography (stress, transthoracic and transesophageal)
    f. Implantable device services: pacemakers, implantable cardioverter-defibrillators
    g. MRI, magnetic resonance angiogram (MRA), PET, PET-CT, CT, computed tomography
    h. Angiography (CTA), Nuclear Medicine
    i. Lipid apheresis
2. Ears, Nose and Throat (ENT)
    a. Bone conduction hearing aids
    b. Cochlear implant
    c. Nasal and sinus surgery
3. Gastroenterology (Stomach)
    a. Gastric electrical stimulation (GES)
4. Neurological
    a. Deep brain stimulation
    b. Sacral nerve neuromodulation/stimulation
    c. Vagus nerve stimulation (VNS)
5. Orthopedic (Musculoskeletal)
    a. Artificial intervertebral disc
    b. Autologous chondrocyte implantation (ACI) for focal articular cartilage lesions
    c. Functional neuromuscular electrical stimulation (FNMES)
    d. Joint and spine surgery
    e. Lumbar spinal fusion
    f. Orthopedic applications of stem-cell therapy
    g. Spinal decompression and fusion surgeries
    h. Total disc replacement surgery
    g. Pneumatic compression devices - Durable Medical Equipment (DME)
6. Pain Management
    a. Epidural steroid spinal injections
    b. Surgical deactivation of headache trigger sites
    c. Interventional pain management
    d. Facet joint spinal injections
    e. Radiofrequency spinal facet joint ablation/denervation
    f. Spinal cord stimulators
    g. Regional sympathetic blocks
    h. Sacroiliac joint injections
    i. Implantable intrathecal drug delivery systems
7. Radiology
    a. Advanced Imaging Services: MRI, magnetic resonance angiogram (MRA), PET, PET- CT, CT, computed tomography angiography (CTA), Nuclear Medicine (including Cardiology
    b. Diagnostic ultrasound: head and neck, pediatric, breast, abdomen and retroperitoneum, extremity, arterial and venous

8. Sleep Medicine
    a. Diagnostic Attended sleep studies and home sleep testing
    b. Positive airway pressure (PAP) therapy devices and supplies; (Sleep CPAP and BiPAP machines)
    c. Positive airway pressure (PAP) therapy compliance monitoring and intervention for non-compliance
9. Surgical Procedures
    a. Orthognathic surgery; face reconstruction
    b. Mastopexy, breast lift
    c. Reduction mammoplasty; breast reduction
10. Specialty Pharmacy
    a. Medical Benefit Specialty Drugs (Specialty drugs administered by your Provider)
11. Wound Care
12. Hyperbaric oxygen (HBO2) therapy. (Expanded Outpatient PA)

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

13. All inpatient treatment of Mental Healthcare/Serious Mental Illness including partial hospitalization programs and treatment received at Residential Treatment Centers
    a. All inpatient treatment of Substance Use Disorder (SUD) including partial hospitalization programs and treatment received at Residential Treatment Centers
    b. If you transfer to another facility or to or from a specialty unit within the facility
    c. The following outpatient treatment of Mental Healthcare, Serious Mental Illness and Substance Use Disorder (SUD)
        i. Psychological Testing or Neuropsychological Testing in some cases (BCBSTX will notify your Provider if Preauthorization is required for these testing services)
        ii. Applied Behavioral Analysis (Please see coverage details as described in the Benefits for Autism Spectrum Disorder in the **COVERED MEDICAL SERVICES** section of this Benefit Booklet)
        iii. Electroconvulsive therapy
        iv. Intensive Outpatient Program
        v. Repetitive Transcranial Magnetic Stimulation

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

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

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

Preauthorization for Inpatient Hospital Admissions

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

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

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

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network Out-of-Network Benefits will not be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network

Benefit level prior to the visit, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

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

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

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

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

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

Preauthorization for Extended Care Expenses and Home Infusion Therapy

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

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

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

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

Preauthorization for Mental Healthcare, and Serious Mental Illness, and Treatment of Substance Use Disorder

In order to receive maximum benefits, all inpatient treatment for Mental Healthcare, and Serious Mental Illness, and Substance Use Disorder must be Preauthorized by the Plan. Preauthorization is also required for certain outpatient services. Outpatient services requiring Preauthorization include psychological testing, neuropsychological testing, repetitive transcranial magnetic stimulation, Intensive Outpatient Programs, Applied Behavior Analysis, and outpatient electroconvulsive therapy. Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

To satisfy Preauthorization requirements, you, a family member, or your Behavioral Health Practitioner must call the Mental Health/Substance Use Disorder Preauthorization Helpline toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The Mental Health/Substance Use Disorder Preauthorization Helpline is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

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

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

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

1. **BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.**
2. **If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.**
3. **You may be responsible for a penalty in the amount of $400 in connection with the following Covered Services when services are received from out-of-network providers:**
    a. **Inpatient Admission**
    b. **Inpatient treatment of Mental Healthcare, and treatment of Serious Mental Illness, and treatment of Chemical Dependency (SUD)**
4. **You may be responsible for a penalty in the amount of $200 in connection with the following Covered Services when services are received from out-of-network providers.**
    a. **Outpatient treatment of Extended Care Expense, Home Infusion Therapy or Ambulatory Surgical Center**

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

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

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Mental Healthcare, and 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.

Preauthorization Renewal Process

Renewal of an existing Preauthorization issued by BCBSTX can be requested by a Physician or healthcare Provider up to 60 days prior to the expiration of the existing Preauthorization.

CLAIM FILING AND APPEALS PROCEDURES

Claim Filing Procedures

Filing of Claims Required

Claim Forms

Claim forms are not required for Benefits to be payable under the Plan. We may request specific information from you or your Employer in order to complete processing of the claim or to verify eligibility in the Plan. The information requested may include but is not limited to:

1. Verification of employment status;
2. Information related to accidental injuries;
3. Information related to work-related accidents or illness; and/or
4. Information regarding any other source of benefits.

Who Files Claims

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

Contracting Providers

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

Non-Contracting Providers

When you receive treatment or care from a healthcare Provider or that does not contract with BCBSTX, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled Participant-filed claims below for instruction on how to file your own claim forms.

Participant-filed claims

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

Visit the BCBSTX website for subscriber claim forms and other useful information: www.bcbstx.com.

Where to Mail Completed Claim Forms

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

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill BCBSTX. Written agreements between BCBSTX and some Providers may require payment directly to them. Any benefits payable to you, if unpaid at your death, will be paid to your beneficiary or to your estate, if no beneficiary is named.

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; and
2. BCBSTX 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 BCBSTX, 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.

BCBSTX 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 BCBSTX from benefit payments of amounts owed to BCBSTX, 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 Plan must be properly submitted within ninety (90) days of the date you receive the services or supplies. Claims not submitted and received by BCBSTX within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by BCBSTX

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

Review Of Claim Determinations

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. You have the right to seek and obtain a review by BCBSTX of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by BCBSTX of your benefits under the Plan.

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

No Replacement for Workers' Compensation

The Plan does not replace Workers' Compensation or provide any Benefits if any Workers' Compensation Benefit was paid or could have been paid, whether or not the Employer is a subscriber or non-subscriber in a Workers' Compensation Program, including those individuals who could have been lawfully covered by Workers' Compensation as volunteers. For purposes of this booklet, work on your family farm or ranch is not considered an employment arrangement requiring Workers' Compensation.

If a Claim Is Denied or Not Paid in Full

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

1. The reasons for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol basis for the determination;
3. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
4. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, healthcare provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
5. An explanation of BCBSTX's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your rights, if any;
6. 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);
7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;
8. 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;
9. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
10. 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;
11. In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claim. An Urgent Care Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
12. Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

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

1. **Urgent Care Clinical Claim** is any Pre-Service Claim that requires Preauthorization, as described in this Benefit Booklet, 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 or a determination with respect to which the terms of the benefit Plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Post-Service Claim** is notification in a form acceptable to BCBSTX that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which BCBSTX may request in connection with services rendered to you.

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

Urgent Care Clinical Claims*

** If the request is received outside the period during which BCBSTX is required to have personnel available to provide determination, BCBSTX will make the determination within one hour from the beginning of the next time period requiring appropriate personnel to be available. You do not need to submit Urgent Care Clinical Claims in writing. You should call BCBSTX at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.*

Note: If a proposed medical care or healthcare service requires preauthorization by BCBSTX, a determination will be issued no later than the third calendar day after BCBSTX's receipt of the request. If you are an inpatient in a healthcare facility at the time the services are proposed, BCBSTX will issue the determination within 24 hours after BCBSTX receives the request.

Pre-Service Claims

Type of Notice or Extension	Timing
If BCBSTX has received all information necessary to complete the review, BCBSTX must notify you within:	2 working days of the receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and 3 calendar days of the request, if the claim is denied.
If you require post-stabilization care after an Emergency within:	the time appropriate to the circumstance not to exceed one hour after the time of request
If your claim is incomplete, BCBSTX must notify you within:	30 days
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	45 days after receiving notice
BCBSTX must notify you of the claim determination (whether adverse or not):	
if the initial claim is complete, within:	30 days*
after receiving the completed claim (if the initial claim is incomplete), within:	45 days, if BCBSTX extended the period, less any days already utilized by BCBSTX during the review

** This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which BCBSTX expects to render a decision. If the period is extended because BCBSTX require additional information from you or your Provider, the period for BCBSTX making the determination is tolled from the date BCBSTX sends notice of extension to you until the earlier of: i) the date on which BCBSTX receives the information; or ii) the date by which the information was to be submitted.*

Concurrent Care

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

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An **Adverse Benefit Determination** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, 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/ Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by BCBSTX and BCBSTX 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.

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to healthcare services, including but not limited to, procedures or treatments ordered by a healthcare provider, the denial of emergency care or continued hospitalization, the denial of a Step Therapy exception request, or the discontinuance by BCBSTX of prescription drugs or intravenous infusions for which you were receiving health benefits under the Plan. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, BCBSTX will provide you with notice and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, BCBSTX will notify the party filing the appeal, as soon as possible, but in no event later than 24 hours after submission of the appeal, of all the information needed to review the appeal. BCBSTX will render a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by BCBSTX.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed 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 some circumstances, a healthcare provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call BCBSTX at the number on the back of your Identification Card.

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

1. Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to BCBSTX to request a claim review. BCBSTX will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:
   Claim Review Section
   Blue Cross and Blue Shield of Texas
   P. O. Box 660044
   Dallas, Texas 75266-0044
2. BCBSTX will honor telephone requests for information; however, such inquiries will not constitute a request for review.
3. In support of your claim review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process. BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the 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 decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal determination will be made by a Physician associated or contracted with BCBSTX and/ or by external advisors, but who were not involved in making the initial denial of your claim.
4. If you have any questions about the claims procedures or the review procedure, write to BCBSTX's Administrative Office or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Timing of Appeal Determinations

BCBSTX will render a determination of the non-urgent concurrent or pre-service appeal as soon as practical, but in no event more than 30 days after the appeal has been received by BCBSTX.

BCBSTX will render a determination of the post-service appeal as soon as practical, but in no event more than 60 days after the appeal has been received by BCBSTX.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call BCBSTX at 855-762-6084. The BCBSTX Customer Service Helpline is accessible 24/7.

Claim Review Section
Blue Cross and Blue Shield of Texas P. O. Box 660044
Dallas, Texas 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 Identification Card for contact information.

Notice of Appeal Determination

BCBSTX will notify the party filing the appeal, you, and, if a clinical appeal, any healthcare 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. The reasons for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual, administrative or protocol basis for the determination;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, healthcare provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
4. An explanation of BCBSTX's external review processes (and how to initiate an external review);
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 BCBSTX;
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, and 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; and
11. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If BCBSTX denies your appeal, in whole or in part, or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party who will review the denial and issue a final decision. Your external review rights are described in the How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO) section below.

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

An **Adverse Determination** means a determination by BCBSTX or its designated utilization review organization that an admission, availability of care, continued stay, or other healthcare service that is a covered service has been reviewed and, based upon the information provided, is determined to be Experimental/Investigational, or does not meet BCBSTX's requirements for Medical Necessity, appropriateness, healthcare setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

A **Final Internal Adverse Benefit Determination** means an Adverse Benefit Determination that has been upheld by BCBSTX at the completion of BCBSTX's internal review/ appeal process.

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

Any party whose appeal of an Adverse Determination is denied by BCBSTX may seek review of the decision by an IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative, or your Provider of record, information on how to appeal the denial, including the approved form, which you, your designated representative, or your Provider of record must complete and submit within four (4) months after your receipt of the Adverse Determination. In life-threatening, urgent care situations, or if BCBSTX has discontinued coverage of intravenous infusions for which you were receiving health benefits under the Plan, you, your designated representative, or your Provider of record may contact BCBSTX by telephone to request the review and provide the required information.

1. BCBSTX will submit medical records, names of Providers, and any documentation pertinent to the decision of the IRO.
2. BCBSTX will comply with the decision by the IRO.
3. BCBSTX will pay for the independent review.

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

1. Information relied upon to make the decision;
2. Information submitted, considered, or generated in the course of making the decision, whether or not it was relied upon to make the decision;
3. Descriptions of the administrative process and safeguards used to make the decision;
4. Records of any independent reviews conducted by BCBSTX;
5. Medical judgments, including whether a particular service is Experimental/Investigational or not Medically Necessary or appropriate; and
6. Expert advice and consultation obtained by BCBSTX in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit you from pursuing other appropriate remedies, including: injunctive relief; a declaratory judgment or other relief available under law, if the requirement to exhaust the process for appeal and review places your health in serious jeopardy.

If you are not satisfied with the outcome of an appeal that has been denied on something other than Medical Necessity or Experimental/Investigational, you may be eligible to file a formal request for final review with TML Health:

1. You must submit your request within thirty (30) days of receipt of the final Adverse Benefit Determination.
2. Your written request for review should include: (1) your specific request for a final formal review; (2) your name, address, and member ID number; (3) your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the Final Review process at the time we receive your request.
3. Should the TML Health Executive Director determine that your request for formal review should be elevated to the TML Health Board of Trustees Executive Committee (Committee) we will schedule a meeting and hear your request. The appealing party may submit additional information and/ or appear before the committee. The appealing party will be notified of the date, time, and place the committee will meet at least five (5) days prior to the meeting date.
4. A final decision will be made and sent to the appealing party. The final decision will be in writing and include specific references to the Plan provisions on which the decision was based. There is no further opportunity to request further review after the TML Health Executive Director and /or Board of Trustees Executive Committee provides their final decision.

Interpretation of Employer's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. Your Employer has given BCBSTX full and complete authority and discretion to make decisions regarding the Plan provisions and determining questions of eligibility and benefits.

Legal Actions Against BCBSTX and TML Health

You must first exhaust the internal appeals procedures before taking any outside legal action. No lawsuit or action in law or equity may be brought by you or on your behalf prior to the expiration of 60 days after Proof of Loss has been filed in accordance with the requirement of the Plan. Further, no such action may be brought after the expiration of one (1) year from the date all appeals rights under this Plan has been exhausted.

Venue for any dispute arising under the terms of the Plan, including but not limited to claims and subrogation disputes or declaratory judgement actions, shall be in Austin, Travis County, Texas.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

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

1. Inpatient Hospital Expenses,
2. Medical-Surgical Expenses,
3. Extended Care Expenses, and
4. Special Provisions Expenses.

Wherever Summary of Benefits and Coverage, (SBC) is mentioned, please refer to your separate SBC for additional coverage information including Deductible, Maximum Out-of-Pocket, Coinsurance and any benefit frequency limitations. The SBC will also identify your Plan anniversary date and if your Deductible, Maximum Out-of-Pocket and other benefit maximums reset on your Plan anniversary date or on a Calendar year basis.

Copayment Amounts

Refer to your SBC to find out if your plan is a Copayment Plan.

Some of the care and treatment you receive under the Plan may require that a Copayment Amount be paid at the time you receive the services. Refer to your SBC for your specific Plan information.

If a Copayment Amount is required for a Physician office visit and the services provided by your Physician require a return office visit on a different day, a new Copayment Amount will be required. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

A Primary Care Copayment Amount, as indicated on your SBC, will be required for each office visit charge you incur when services are rendered by a family practitioner, an obstetrician/gynecologist, a pediatrician, a Behavioral Health Practitioner, an internist, or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed Physicians.

A Specialty Copayment Amount, as indicated on your SBC, will be required for each office visit charge you incur:

1. When services are rendered by a Specialty Care Provider (as classified by the American Board of Medical Specialties as a Specialty Care Provider), or
2. When services are rendered by any other Professional Other Provider as defined in the **DEFINITIONS** section of this Benefit Booklet; with the exception of services provided by a Physician Assistant or Advanced Practice Nurse as described in the preceding paragraph.

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

1. Surgery performed in the Physician's office;
2. Physical therapy billed separately from an office visit;
3. Occupational modalities in conjunction with physical therapy;
4. Allergy injections billed separately from an office visit;
5. Any services requiring Preauthorization;
6. Certain Diagnostic Procedures;
7. Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

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

A Copayment Amount, if shown on your SBC, will be required for each Virtual Visit.

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

Deductible(s) *(Refer to the SBC)*

The benefits of the Plan will be available after satisfaction of the applicable Deductible(s) as shown on your SBC. Your SBC will indicate if the Deductible resets itself at the beginning of each Plan Anniversary date or at the beginning of each Calendar year. This will be referred to as the Benefit Plan Year.

The Deductible(s) are explained as follows:

1. In-Network and Out-Of-Network Deductibles are separate. The Out-Of-Network Deductible accumulates to the In-Network Deductible; the In-Network Deductible does not accumulate to the Out-Of-Network Deductible.

2. The In-Network Deductible is included in the In-Network Maximum Out-of-Pocket.
3. Covered Charges that are used toward satisfying the Deductible must be Incurred during the Benefit Plan Year.
4. The family Deductible is a cumulative dollar amount and applies collectively to all covered family individuals. Once the family Deductible is satisfied, no further Deductible requirements will be applied for any covered family individual within the Benefit Plan Year.
5. If you are on a Qualified High Deductible/Health Savings Account (HSA) plan and are covering any Dependents, refer to your SBC to find out if your Plan has an individual Deductible for each member of the family, or a family Deductible that must be met in full before the Plan will pay. In the case of a family deductible plan, if any individual on the Plan meets the Federal Individual Maximum Out-of-Pocket Amount, the Plan will begin to pay for In-Network services for that person.

Maximum Out-of-Pocket *(Refer to the SBC)*

Your SBC will indicate if the Maximum Out-of-Pocket resets itself at the beginning of each Plan Anniversary date or at the beginning of each Calendar year. This will be known as the Benefit Plan Year.

Covered charges that are used toward satisfying the Maximum Out-of-Pocket Amount must be incurred during the Benefit Plan Year. Only covered In-Network expenses accumulate to the Maximum Out-of-Pocket Amount.

The family Maximum Out-of-Pocket Amount is a cumulative dollar amount and applies collectively to all covered family individuals. Once the family Maximum Out-of-Pocket Amount is satisfied, the plan will pay 100% for all In-Network services for any covered family member during the remainder of the Benefit Plan Year.

If you are on a Qualified High Deductible/HSA plan and are covering any Dependents, refer to your SBC to find out if your Plan has an individual Maximum Out-of-Pocket Amount for each member of the family, or a family out-of-pocket that must be met in full before the Plan will pay at 100%. In the case of a family out-of-pocket plan, if any individual on the Plan meets the Federal Individual Maximum Out-of-Pocket Amount, the Plan will begin to pay 100% for In-Network services for that person.

COVERED MEDICAL SERVICES

The Plan will reimburse for the following types of medical care for Employees, subject to the conditions and/or limitations described in this booklet and the SBC.

Inpatient Hospital Expenses

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

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

Refer to the SBC for information regarding Deductibles, coinsurance percentages and penalties for failure to preauthorize that may apply to your coverage.

Hospital

1. Private Room - administratively, room and board charges are allowed up to the rate for a Semi-Private Room;
2. intensive care room and board up to the Reasonable and Customary rate; and
3. ancillary services and supplies.

Medical-Surgical Expense

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

Outpatient Hospital

Supplies and services provided by the facility on an Outpatient basis.

Facility Outpatient

Ambulatory Surgical Center (ASC)

Charges for surgical procedures performed by a Physician including charges Incurred for covered related services and supplies furnished on the day of surgery. If the office or facility does not meet the definition of an Ambulatory Surgical Center as defined in this booklet, surgical facility charges will not be covered.

Medical-Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers.
2. Consultation services of a Physician and Professional Other Provider.
3. Services of Surgeons performing the role of Co-Surgeon or Assistant Surgeon.
4. Services of an Anesthesiologist or a certified registered nurse-anesthetist (CRNA).
5. Services provided by a Certified Nurse Midwife, (CNM)/ Certified Professional Midwife (CPM) in connection with normal pregnancy and delivery care.
6. Services from a Doctor of Chiropractic, (DC) – refer to the SBC for benefit maximum.
7. Diagnostic X-Ray and laboratory procedures.
8. Radiation therapy.
9. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by BCBSTX. The term “durable medical equipment (DME)” shall not include:
    a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
    b. Home air fluidized bed therapy. Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.
    c. Charges for the rental of Durable Medical Equipment in excess of the purchase price are not covered.

    Replacement of non-warranty equipment, prosthetics, non-foot orthotics, implantable and/ or removable auditory and/or ocular prosthetics will be an Eligible Benefit if lost, stolen, or damaged beyond repair in an accident or a natural disaster. Proof of damage or theft will be required. If equipment is worn out, replacement of equipment will be considered if the equipment exhausts the five-year equipment lifetime requirement. Physiological and/or technological medical necessity approval will be required for replacement of equipment prior to the five-year lifetime replacement timeline.

10. For Emergency Care, professional local ground ambulance transportation or air ambulance transportation to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition. Non-Emergency ground ambulance transportation from one acute care Hospital to another acute care Hospital for diagnostic or therapeutic services (e.g., MRI, CT scans, acute interventional cardiology, intensive care unit services, etc.) may be considered Medically Necessary when specific criteria are met. The non-emergency ground ambulance transportation to or from a hospital or medical facility, outside of the acute care hospital setting, may be considered Medically Necessary when the Participant's condition is such that trained ambulance attendants are required to monitor the Participant's clinical status (e.g., vital signs and oxygenation), or provide treatment such as oxygen, intravenous fluids or medications, in order to safely transport the Participant, or the Participant is confined to bed and cannot be safely transported by any other means. Non-Emergency ground ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary. (Refer to the SBC). Non-Emergency air ambulance transportation means transportation from a Hospital emergency department, healthcare facility, or Inpatient setting to an equivalent or higher level of acuity facility, and may be considered Medically Necessary when the Participant requires acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Non-Emergency air ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.
11. Anesthetics and their administration, when performed by someone other than the operating Physician or Professional Other Provider.
12. Oxygen and its administration provided the oxygen is actually used.
13. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
14. Blood Storage when in connection with scheduled surgery or procedure covered under the plan.
15. Artificial limbs or prosthetic appliances: Medically Necessary new or replacement appliances are limited to the lessor of contractual charge, Reasonable and Customary fee schedule defined by the Plan Document, or cost of the standard model.
16. Prosthetic bra, camisole, and breast prosthesis: For an oncology-related mastectomy.
17. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg, or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips, or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.
18. Infusion Therapy.
19. Eligible services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency (SUD) Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
20. Certain Diagnostic Procedures.
21. Lab and Xray changes
22. Foot care in connection with the treatment of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.
23. Prescription Drugs administered in a medical setting
    a. Coverage for Specialty Injectables that are also available through the Prescription Drug Plan but are purchased from medical providers may require Preauthorization and will be paid per the Medical Benefit Plan. Contract the Customer Service Helpline at 855 762 6084 to find out if the Specialty Drug requires Pre-authorization.
    b. Prescription Drug Plan non-injectable prescriptions purchased outside of the Pharmacy Benefit Manager will not be an eligible Benefit under the Medical Benefit Plan other than the Medical Plan Specialty Injectable Benefit mentioned above.
    c. Refer to the Prescription Drug Plan booklet for more information.
24. Cardiac Rehabilitation to improve cardiovascular function.
25. Genetic/Genomic Medically Necessary evidence-based testing to direct Treatment (after diagnosis has been established) and/or maternity-related amniocentesis.
26. Hormone replacement therapy: For hormonal imbalance.
27. Infertility diagnostic: Initial diagnosis only.
28. Lenses: Initial removable contact lenses or glasses required following cataract surgery. (Refer to SBC.) Standard implantable ocular prosthetics to treat cataract and/or complex corneal diseases

29. Nursing services
    a. Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) for professional nursing services.
    b. Inpatient private duty nursing will be limited to Medically Necessary services.
    c. Advanced Nurse Practitioner (ANP) for nursing services including charges as an assistant in surgery. If assisting in surgery, the ANP must meet eligibility guidelines.
    d. Registered Nurse First Assistant (RNFA) if assisting in surgery. The RNFA must meet eligibility guidelines.
30. Nutritional counseling: Services provided by a licensed dietitian or certified diabetes educator.
31. Oophorectomy: Evidence-based Genetic Testing for ovaries with positive results will be required before a prophylactic oophorectomy will be considered as an eligible Benefit.
32. Respiratory rehabilitation: A program of clinically supervised exercise and intervention designed to strengthen the lungs and improve pulmonary/ respiratory functioning; requires request to care management.
33. Surgical sterilization: Eligible Benefits.
34. Telehealth services
    a. Medical information that is communicated in real-time with the use of interactive audio and video communications equipment and is between the treating Physician and/ or a distant Physician or healthcare specialist with the patient present during the communication.
    b. Telemedicine and Telehealth services, which are services by a Physician or other licensed healthcare professional and you when not at the same site. Eligible services will include audio/visual evaluation and management
35. Testosterone injections: For evidence-based hormonal imbalance.
36. Ultrasound and/or sonograms for pregnancy.
37. Wig: For oncology-related hair loss; subject to the Benefit maximum as stated in the SBC.

Extended Care Expense

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

BCBSTX's benefit obligation as shown on your SBC will be:

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

If shown on your SBC, the Benefit Plan Year Deductible will apply. Any unpaid Extended Care Expense will not be applied to any Out-of-Pocket Maximums.

For Hospice Care that is provided in a Hospital, the Benefit Plan Year Deductible for Inpatient Hospital Expense, if shown on your SBC, will apply.

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

Services and supplies for Extended Care Expense:

1. For Skilled Nursing Facility:
    a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
    b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
    c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.
2. For Home Health Care:
    a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
    b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
    c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
    d. Supplies and equipment routinely provided by the Home Health Agency. Benefits will not be provided for Home Health Care for the following:
        i. Food or home delivered meals;
        ii. Social case work or homemaker services;
        iii. Services provided primarily for Custodial Care;
        iv. Transportation services;
        v. Home Infusion Therapy;
        vi. Durable medical equipment.
3. For Hospice Care:
    a. For Home Hospice Care:
        i. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
        ii. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
        iii. Physical, speech, and respiratory therapy services by licensed therapists;
        iv. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.
    b. For Facility Hospice Care:
        i. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
        ii. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
        iii. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this Special Provisions Expenses subsection are generally determined on the same basis as other Inpatient Hospital Expense, Medical-Surgical Expense, and Extended Care Expense, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your SBC. Remember that certain services require Preauthorization and that any Copayment Amounts, Coinsurance Amounts, Out-of-Pocket Maximums and Deductibles shown on your SBC will also apply.

Benefits for Treatment of Complications of Pregnancy

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

Benefits for Maternity Care

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

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

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

1. 48 hours following an uncomplicated vaginal delivery; and
2. 96 hours following an uncomplicated delivery by caesarean section.

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

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

1. Parent education,
2. Assistance and training in breast-feeding and bottle feeding, and
3. The performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination and administration of a newborn screening test (which includes the test kit, required by the state of Texas) during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions and benefit maximums as described under Inpatient Hospital Expenses. Benefits will also be subject to any Deductible amounts shown on your SBC.

Mental Healthcare

The Plan provides Benefits for the Treatment of Mental Health conditions. Expenses for the Treatment of Serious Mental Illness conditions are considered the same as any other Illness for the Plan's Deductible and Coinsurance as stated in the SBC. Expenses not considered as serious Mental Health conditions will be subject to the Plan's Coinsurance. An order by a court or state agency for Treatment is not an indication of eligibility.

Outpatient Treatment

The Plan will reimburse up to twenty-six (26) individual visits or group therapy sessions per Year for the eligible Treatment of a Mental Health condition. Medication checks and psychological testing do not accumulate to the twenty-six (26) individual visits.

Intensive Outpatient Therapy Program

Intensive Outpatient Therapy individual visits or group sessions will accumulate to the Outpatient visit Benefit of twenty-six (26) visits per year. The program must treat you for either sixteen (16) hours per week or for a four (4) hour daily session.

Inpatient Treatment

An Inpatient Confinement requires a Preauthorization request. Please see the **PREAUTHORIZATION REQUIREMENTS** in the Preauthorization Requirements section. The Plan will reimburse up to fourteen (14) Inpatient days each Year for the eligible Treatment of a Mental Health condition.

Alternative Settings Benefit

Residential Treatment requires a Preauthorization request. Please see the **PREAUTHORIZATION REQUIREMENTS** in the Preauthorization Requirements section.

The Plan will reimburse up to seven (7) alternative setting days each Year for the eligible Treatment of Mental Health conditions while confined in a residential treatment center, subject to the following restrictions:

1. You must have a Mental Health condition which would otherwise necessitate Hospital Confinement;
2. Services must be based on an individual treatment plan; and
3. Providers of services must be properly licensed.

Day Treatment

The Plan will reimburse up to fourteen (14) Day Treatment visits per Year. The facility must treat you for a minimum of four (4) hours in any twenty-four (24) hour period and a minimum of five (5) days per week. The attending Physician must document that such Treatment is in lieu of hospitalization. A Preauthorization request is required. Please see the **PREAUTHORIZATION REQUIREMENTS** in the Preauthorization Requirements section.

Serious Mental Illness

Expenses Incurred by you for Treatment of Serious Mental Illness are payable as any other Illness. The term Serious Mental Illness means the following Mental Health conditions as defined by the American Psychiatric Association in the latest version of the Diagnostic and Statistical Manual (DSM):

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

Chemical Dependency Substance Use Disorder, (SUD) Benefit

The Plan provides Benefits for the Treatment of Chemical Dependency/ SUD. The benefit is limited to a maximum of three (3) lifetime Treatment series that may include: Inpatient detoxification, Inpatient rehabilitation or Treatment, partial hospitalization, Intensive Outpatient Treatment, Outpatient Treatment, or a series of those levels of Treatments without a lapse in Treatment in excess of thirty (30) days. An order by a court or state agency for Treatment is not an indication of eligibility for Benefits under the Plan.

Outpatient Treatment Series

The Plan will reimburse up to twenty-six (26) individual visits or group therapy sessions for the eligible Treatment for Chemical Dependency/SUD. Medication checks and psychological testing do not accumulate to the twenty-six (26) individual visits.

Intensive Outpatient Therapy Program

Intensive Outpatient Therapy individual visits or group sessions will accumulate to the Outpatient visit Benefit of twenty-six (26) visits. The program must treat you for either sixteen (16) hours per week or for a four (4) hour daily session.

Inpatient Treatment Series

All Inpatient Confinements require a Preauthorization request. Please see the **PREAUTHORIZATION REQUIREMENTS** in the Preauthorization Requirements section. The Plan will reimburse up to fourteen (14) Inpatient days for the medically eligible Treatment of a Chemical Dependency/SUD condition.

Alternative Settings Benefit

Residential Treatment requires a Preauthorization request. Please see the **PREAUTHORIZATION REQUIREMENTS** in the Preauthorization Requirements section.

The Plan will reimburse up to seven (7) alternative setting days for the eligible Treatment of a Chemical Dependency/ SUD condition while confined in a residential treatment center, subject to the following restrictions:

1. You must have a Chemical Dependency/SUD which would otherwise necessitate Hospital Confinement;
2. Services must be based on an individual treatment plan; and
3. Providers of services must be properly licensed.

Day Treatment Series

The Plan will reimburse up to fourteen (14) days for the eligible Treatment of a Chemical Dependency/SUD condition. The facility must treat you for a minimum of four (4) hours in any twenty-four (24) hour period and a minimum of five (5) days per week. The attending Physician must document that such Treatment is in lieu of hospitalization. A Preauthorization request is required. Please see the **PREAUTHORIZATION REQUIREMENTS** in the Preauthorization Requirements section.

Benefits for Emergency Care

The Plan provides coverage for Emergency Care. Services provided in an emergency room, freestanding emergency room, or other comparable facility that are not Emergency Care may be excluded from Emergency Care coverage, although these services may be covered under another benefit if applicable.

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

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

In-Network and Out-of-Network Benefits for Eligible Expenses for Emergency Care, including Emergency Care for Behavioral Health Services and Accidental Injury, will be determined as shown on your SBC. Copayment Amounts may be required for facility charges for each emergency room/ treatment room visit if shown on your SBC. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived. If admitted for the emergency condition immediately following the visit, Preauthorization of the inpatient Hospital Admission will be required, and Inpatient Hospital Expenses will apply.

If you continue to be treated by an Out-of-Network Provider after you receive Emergency Care and you can safely be transferred to the care of an In-Network Provider, only Out-of-Network Benefits will be available.

For Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount shall be usual and customary rate or at a rate agreed to between BCBSTX and the non-contracting Provider, not to exceed billed charges. The Plan's usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less that the non-contracting Allowable Amount as defined in this Plan.

Benefits for Retail Health Clinics

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

Benefits for Virtual Visits

Benefits for Eligible Expenses for Virtual Visits will be determined as shown on your SBC. BCBSTX provides you with access to Virtual Providers that can provide diagnosis and treatment of non-emergency medical and behavioral health conditions in situations that can be handled without a traditional primary care office visit, behavioral health office visit, Urgent Care visit, or Emergency Care visit. Covered Services may be provided via 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, contact customer service at the toll-free number on the back of your Identification Card.

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

Preventive Care Services

Preventive care services will be provided for the following covered services:

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 ("USPSTF");
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
3. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
4. With respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA.

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

The preventive care services described in items a. through d. may change as USPSTF, CDC and HRSA guidelines are modified and will be implemented by BCBSTX in the quantities and at the times required by applicable law or regulatory guidance. For more information, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on your Identification Card.

Examples of covered services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density test, screening for colorectal cancer, smoking cessation counseling services and healthy diet counseling and obesity screening/counseling.

Note: Tobacco cessation medications are covered under your prescription plan, when prescribed by a Healthcare Practitioner.

Note: Preventive Care services do include those services billed with a family history diagnosis.

Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive care services included in items a. through d. above provided by an In-Network Provider will not be subject to Coinsurance, Deductible, Copayment or dollar maximums. Deductibles and coinsurance are not applicable to immunizations covered under ***Required Benefits for Childhood Immunizations*** provision.

Preventive care services included in items a. through d. above provided by an Out-of-Network Provider will be subject to Coinsurance and Deductibles.

Covered services not included in items a. through d. above may be subject to Coinsurance, Deductible, Copayment and/or dollar maximums.

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

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

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

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

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer recommended for a Participant 35 years of age and older, except that benefits will not be available for more than one routine mammography screening each Year. Low-dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Detection and Prevention of Osteoporosis

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

Qualified Individual means:

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

Benefits for Tests for Detection of Colorectal Cancer

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

1. A fecal occult blood test performed annually and a flexible sigmoidoscopy recommended to be performed every five years; or
2. A colonoscopy recommended to be performed every ten years.
3. Colorectal DNA screening, (i.e. Cologuard), limited to one test every three years.

Benefits for Outpatient Contraceptive Drugs, Devices, and Procedures Not Subject to Coinsurance, Deductible, Copayment, or Benefit Maximum

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

*Note: Prescription contraceptive medications are covered under the **PHARMACY BENEFITS** portion of your Plan.*

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

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

Benefits will be provided for female sterilization procedures for women with reproductive capacity and Outpatient

Contraceptive Services benefits. Also, benefits will be provided for FDA approved over-the-counter female contraceptives with a written prescription by a Healthcare Practitioner. Services are covered under your Prescription Drug Plan.

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

Benefits for Breastfeeding Support, Services and Supplies

Benefits will be provided for breastfeeding counseling and support services when rendered by a Provider, during pregnancy and/or in the post-partum period. Benefits include the rental (or at the Plan's option, the purchase) of manual or electric breast pumps, accessories, and supplies. Benefits for electric breast pumps are limited to one per Year. Limited benefits are also included for the rental only of hospital grade breast pumps. You may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual, electric, or hospital grade breast pump, accessories and supplies. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.

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

Contact Customer Service at the toll-free number on the back of your Identification Card for additional information.

Benefits for Early Detection Test for Ovarian Cancer

Benefits are available for a CA 125 blood test recommended once every twelve months for each woman enrolled in the Plan who is age 18 years of age or older. Benefits are subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally.

Benefits for Certain Tests for Detection of Prostate Cancer

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

1. 50 years of age and asymptomatic; or
2. 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits are subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally.

Benefits for Diagnostic Mammograms

Diagnostic Mammograms are covered to the same extent as Benefits for Mammogram Screenings as described in the Preventive Care Services section when billed with a preventative diagnosis.

In addition to the applicable terms provided in the **DEFINITIONS** section of the Benefit Booklet, the following term will apply specifically to this provision.

Diagnostic Mammogram means an imaging examination designed to evaluate:

1. A subjective or objective abnormality detected by a Physician in a breast;
2. An abnormality seen by a Physician on a screening mammogram;
3. An abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or
4. An individual with a personal history of breast cancer.

The Copayment Amounts and Coinsurance Amounts shown on your SBC will apply, after the Deductible.

Required Benefits for Childhood Immunizations

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

Benefits are available for:

1. Diphtheria,
2. Hemophilus influenza type b,
3. Hepatitis B,
4. Measles,
5. Mumps,
6. Pertussis,
7. Polio,
8. Rubella,
9. Tetanus,
10. Varicella, and
11. Any other immunization that is required by law for the child.

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

Benefits for Certain Therapies for Children with Developmental Delays

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas Human Resources Code.

Such therapies include:

1. Occupational therapy evaluations and services;
2. Physical therapy evaluations and services;
3. Speech therapy evaluations and services; and
4. Dietary or nutritional evaluations

The Individualized Family Service Plan must be submitted to BCBSTX prior to the commencement of services and when the Individualized Family Service Plan is altered.

After the age of 3, when services under the Individualized Family Service Plan are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

1. Cognitive development;
2. Physical development;
3. Communication development;
4. Social or emotional development; or
5. Adaptive development.

Individualized Family Service Plan means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention.

Required Benefits for Screening Tests for Hearing Impairment

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

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

Deductibles indicated on your SBC will not apply to this provision.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your SBC. A mandatory pre-determination of benefits is required for the following cosmetic procedures:

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
2. Treatment provided for reconstructive surgery following cancer surgery; or
3. Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
4. Surgery performed for the treatment or correction of a congenital defect other than conditions of the breast.

Reconstruction of the breast on which mastectomy has been performed is a covered benefit; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy. Eligible Benefits include the initial non-cosmetic removal and replacement of prosthetics due to complications. Reconstructive Surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.

Breast Reduction is a covered benefit if in compliance with Evidence-Based (EBM) criteria for approval.

Reconstructive surgery performed due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease is a covered benefit.

Surgery to correct congenital defects is limited to children under the age of nineteen (19) years is a covered benefit.

Benefits for Dental Services

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

1. The excision of non-dental-related neoplasms, including benign tumors and cysts and situations where proper medical evidence indicates a tumor or cyst is present, and all malignant lesions and growths;
2. The incision and drainage of facial cellulitis;
3. Surgical procedures involving salivary glands and ducts and non-dental-related procedures of the accessory sinuses;
4. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint (TMJ);
5. Repair or alleviation of damage to sound natural teeth caused solely by accidental bodily Injury, other than a chewing Injury, treated within twelve (24) months of the Injury.

A Pre-determination of Benefits is recommended for any other dental-related service requested to be considered under the Plan.

If a Participant is unable to undergo dental treatment in a dental office or under local anesthesia due to a documented physical, mental or medical reason, as determined by the Participant's Physician or by the dentist providing the dental care, a Participant shall have coverage for Medically Necessary, non-dental related services to the dental treatment.

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

Benefits For The Treatment of Temporomandibular Disorders (TMJ)

Treatment for any jaw joint disorder, TMJ disorder, craniomaxillary or craniomandibular disorder, or other conditions of the joint linking the jawbone and skull is payable for Medically Necessary eligible charges limited to:

1. An examination including a history, physical examination, muscle testing, range of motion measurements, and psychological evaluation, as necessary;
2. Diagnostic X-Rays;
3. Physical therapy of necessary frequency and duration, limited to a multiple modality Benefit when more than one therapeutic procedure is performed on the same date of service;
4. Therapeutic injections;
5. Orthotic appliance for therapy utilizing an appliance that does not permanently alter tooth position, jaw position, or the bite. Benefits for appliance therapy are limited to use of an appliance, including jaw relations, bite registration, training, office visits, adjustments and repairs; and
6. Surgical Treatment of TMJ.

Benefits for the Treatment of Morbid Obesity

Morbid obesity is defined as a body mass index (BMI) greater than 40 kg/m^2 or a BMI greater than 35 kg/m^2 with associated complications including, but not limited to, diabetes, hypertension, dyslipidemia, diabetes, coronary heart disease, sleep apnea or osteoarthritis in weight bearing joints. This benefit is limited to adults age 18 and over or adolescents who have attained a Tanner 4 or 5 pubertal development or have a bone age $\geq$ 13 years in girls, or $\geq$ 15 years in boys.

Documentation is required from the surgeon attesting the patient has been educated, understands, and is willing to comply with the post-operative regime including the following:

1. Nutrition program, which may include a very low calorie diet or a recognized commercial diet-based weight loss program; and
2. Behavior modification or behavioral health interventions; and
3. Counseling and instruction on exercise and increased physical activity; and
4. Ongoing support for lifestyle changes to make and maintain appropriate choices that will reduce health risk factors and improve overall health.

In addition, the patient must have undergone a psychiatric evaluation within the 12 months preceding the request for surgery.

Prior to undergoing any Bariatric surgery, your physician must submit a pre-determination of benefits to confirm you meet the above requirements and the procedure is deemed Evidence-Based Medicine Morbid Obesity Treatment as determined by the plan. Eligible Benefits are subject to the lifetime maximum morbid obesity Benefit limitation. (Refer to the SBC.)

Bariatric surgery must be performed at a Blue Cross and Blue Shield designated Center of Excellence. This includes any non-emergent complications.

Weight-Loss Counseling

This plan offers a ten (10) week online behavioral counseling program through our partner Wondr Health® for weight management. To be eligible to participate, you must be eighteen (18) years or older, have a body mass index (BMI) of thirty (30) or higher, or twenty-five (25) to twenty-nine (29) BMI with metabolic syndrome risk factors, and your Employer must sponsor/participate in the program. There is no cost to participate in this program.

This simple online program uses videos and learning tools to teach you how to lose weight and improve your health. It is available via your desktop, laptop, or mobile device, including apps for both iPhone and Android devices.

Benefits for Organ and Tissue Transplants

Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

1. The transplant procedure is not Experimental/ Investigational in nature; and
2. Donated human organs or tissue or an FDA-approved artificial device are used; and
3. The recipient is a Participant under the Plan; and
4. The transplant procedure is preauthorized as required under the Plan; and

5. The Participant meets all of the criteria established by BCBSTX in pertinent written medical policies; and
6. The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

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

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

   Benefits will be available for:

   a. A recipient who is covered under this Plan; or
   b. A donor who is a Participant under this Plan as long as the recipient is covered under this plan; or
   c. A donor who is not a Participant under this Plan if the donor's own plan does not provide coverage for organ acquisition or procurement.

2. Covered services and supplies include services and supplies provided for the:
   a. Donor search and acceptability testing of potential live donors; and
   b. Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
   c. Removal of organs or tissues from living or deceased donors; and
   d. Transportation and short-term storage of donated organs or tissues.

3. No benefits are available for a Participant for the following services or supplies:
   a. Expenses if you donate an organ and/or tissue and the recipient is not an Employee under this Plan.
   b. Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells, or bone marrow, unless you have been diagnosed with a condition for which there would be Approved Transplant Services.
   c. Expenses for any post-transplant complications of the donor, if the donor is not a covered person under this Plan.
   d. Expenses for an Unproven Medical Procedure or a Phase I and/or II clinical trial as defined in this booklet.
   e. Expenses that involve an artificial (mechanical) organ or non-human tissue.
   f. Expenses related to, or for, the purchase of any organ.
   g. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which BCBSTX considers to be Experimental/Investigational.

E. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** section in this Benefit Booklet for more specific information about Preauthorization.
   1. Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization.
   2. At the time of Preauthorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

Transplant Related Travel Expenses Benefit

This Plan has a $15,000 maximum travel expense Benefit paid per lifetime that includes all travel and lodging costs for the recipient and adult companions (if more than seventy-five (75) miles one way to the Designated Transplant Facility from employee's home).

Travel reimbursement:

1. Private vehicle use will be reimbursed at the maximum allowable amount determined by the Internal Revenue Service, and reimbursement is limited to travel between home and the Transplant Center. Airfare will be reimbursed at cost.
2. The Plan provides for ground or air transportation of you to and from the pre-transplant evaluation, organ transplantation, and any other Eligible Benefit or follow-up appointment.
3. The Plan provides for ground or air transportation of eligible companions to and from the pre-transplant evaluation, organ transplantation, and any other eligible provider services or follow-up appointment.

Receipts will be required for reimbursement and submitted on a Transplant Travel and Lodging Reimbursement Form, available at www.BCBSTX.com.

Transplant Benefits will be payable for up to twelve (12) months from the date of the Transplant while you are receiving services at the transplant facility.

This Plan will pay travel and lodging Benefits for a non-covered living donor only after any other coverage that the living donor has is exhausted.

Corneal Transplant is not covered under the above transplant benefit but will be covered as any other major medical benefit.

Benefits for Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are covered.

Individuals providing treatment prescribed under that plan must be:

1. A Healthcare Practitioner:
    a. who is licensed, certified, or registered by an appropriate agency of the state of Texas;
    b. whose professional credential is recognized and accepted by an appropriate agency of the United States; or
    c. who is certified as a provider under the TRICARE military health system; or
2. An individual acting under the supervision of a Healthcare Practitioner described in 1 above. For purposes of this section, generally recognized services may include services such as:
    a. Evaluation and assessment services;
    b. Screening at 18 and 24 months;
    c. Applied Behavior Analysis;
    d. Behavior training and behavior management;
    e. Speech therapy;
    f. Occupational therapy;
    g. Physical therapy; or
    h. Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Benefits for Autism Spectrum Disorder will apply towards any maximum indicated on your SBC.

All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions and Preauthorization.

Preauthorization will assess whether services meet coverage requirements. Review the **PREAUTHORIZATION REQUIREMENTS** section in this Benefit Booklet for more specific information about Preauthorization.

Please see the definition of "Qualified ABA Provider" in the **DEFINITIONS** section of this Benefit Booklet for more information.

Benefits for Treatment of Diabetes

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

Diabetes Equipment and Supplies

Coverage for equipment and supplies for the Treatment of diabetes for which a Physician or practitioner has written an order, including:

1. Blood glucose monitors, including those designed to be used by or adapted for the legally blind*;
2. Test strips specified for use with a corresponding glucose monitor*;
3. Lancets and lancet devices*;
4. Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein*;
5. Insulin and insulin analog preparations*;
6. Injection aids, including devices used to assist with insulin injection and needleless systems*;
7. Insulin syringes*;
8. Biohazard disposal containers;
9. Insulin pumps, both external and implantable, and associated supplies, which include:
    a. Insulin infusion devices;
    b. Skin preparation items;
    c. Adhesive supplies;
    d. Infusion sets;
    e. Insulin cartridges;
    f. Durable and disposable devices to assist in the injection of insulin; and
    g. Other required disposable supplies;
10. Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
11. Prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level*;
12. Podiatric appliances, for the prevention of complications associated with diabetes; and
13. Glucagon emergency kits*.

**These items are only covered under the Prescription Drug Plan*

Diabetes Self-Management Education

1. Education provided after the initial diagnosis of diabetes in the care and management of that condition, including the development of an individualized management plan, nutritional counseling, and proper use of diabetic equipment and diabetic supplies;
2. Additional education authorized on the diagnosis of a Healthcare Provider of a significant change in your symptoms or condition of diabetes that requires changes in your self-management regime;
3. Periodic or episodic continuing education when prescribed by an appropriate Healthcare Provider as warranted by the development of new techniques and treatments for diabetes; and
4. Another medical condition associated with elevated blood glucose levels.

Benefits for Physical Medicine Services

Services prescribed and performed by a licensed practitioner to restore, keep, learn, or improve skills and functions for daily living. These include physical, occupational, and speech therapy services.

Services in a home setting must be preauthorized and will apply to the Home Health Care benefit maximum *(Refer to the SBC)*.

Benefits for Physical Medicine Services are available as shown on your SBC.

All benefit payments made by BCBSTX for Physical Medicine Services, whether under the In-Network or Out-of-Network Benefits level, will apply toward the benefit maximum under each level of benefits.

Benefits for Custom Molded Foot Orthotics

Medical, documented physiological change that requires a revised orthotic; subject to the Benefit maximum. (Refer to the SBC.)

Benefits for Speech and Hearing Services

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

If a "Hearing Aids maximum" is indicated on your Schedule of Coverage, any benefit payments made by BCBSTX for hearing aids, whether under the In-Network Benefits or Out-of-Network Benefits level, will apply toward the benefit maximum amount.

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

Benefits for Routine Patient Costs for Participants in Approved Clinical Trials

Benefits for Eligible Expenses for Routine Patient Care Costs are provided in connection with a phase I, phase II, or phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

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

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

MEDICAL LIMITATIONS AND EXCLUSIONS

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

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by BCBSTX.
4. For Treatment of any Illness, Injury, or disability which (a) was Incurred while working for wage, hire, or monetary gain, or (b) could have been available if pursued under benefits for Workers' Compensation whether or not the Employer is a subscriber or non- subscriber in a Workers' Compensation Program, and whether or not the injured person could have been lawfully covered by Workers' Compensation as a volunteer. In applying this exclusion, work on your family farm or ranch is not considered an employment arrangement.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except any program which is a state or federal plan for medical assistance (i.e., Medicaid or Medicare); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. Any services or supplies provided for injuries sustained:
    a. As a result of war, declared or undeclared, or any act of war; or
    b. While on active or reserve duty in the armed forces of any country or international authority.
9. Any charges:
    a. Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
    b. For completion of any insurance forms; or
    c. For acquisition of medical records.
10. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
12. Over-the-counter supplies or medicines and prescription drugs and medications of any kind, except:
    a. As provided while confined as an inpatien;
    b. As provided under Diabetes Care;
    c. Contraceptive devices and FDA-approved over-the counter contraceptive for women with a written prescription from a Participating Provider;
    d. For drugs and medicines lawfully obtainable without a Physician's prescription (even if prescribed by a Physician) including but not limited to vitamins, cosmetics, dietary supplements, over-the-counter nutritional formulas used as food replacement, over-the-counter home tests, homeopathic remedies, and/or alternative remedies; or
    e. For prescription drugs, supplies, and equipment dispensed on an Outpatient basis which are covered under a Prescription Drug Program (including lifestyle medications, Copayments and any required payment differentials between generic and brand name drugs).
13. Any services or supplies provided for Custodial Care, Maintenance Care or Convalescent Care.
14. Any Treatment of the temporomandibular joint (TMJ) or jaw-related neuromuscular conditions not listed as an Eligible Benefit.
15. Any items of Medical-Surgical Expense incurred for dental care and treatments, Covered Oral Surgery, or dental appliances, except as provided for in the Benefits for Dental Services provision in the Special Provisions Expenses portion of this Benefit Booklet.

16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the Benefits for Cosmetic, Reconstructive, or Plastic Surgery provision in the Special Provisions Expenses portion of this Benefit Booklet.
17. Eye examinations for the purpose of prescribing corrective lenses or determining visual acuity or for Treatment of refractive errors, eye glasses, or contact lenses (including the fitting thereof), orthoptics, vision therapy, or other special vision procedures including but not limited to Radial Keratotomy (RK), Laser Assisted In-Situ Keratomileusis (LASIK), and Excimer Laser Photorefractive Keratectomy (PRK).
18. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the Benefits for Physical Medicine Services and Benefits for Autism Spectrum Disorder provision in the Special Provisions Expenses portion of this Benefit Booklet.
19. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.
20. Any services or supplies provided primarily for:
    a. Environmental Sensitivity;
    b. Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    c. Inpatient allergy testing or treatment.
21. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
22. Services, medication, devices, and supplies relating to the lifestyle treatment of erectile dysfunction, impotence, and decreased libido.
23. Any procedures, equipment, services, supplies, or charges for elective abortions except in the case of incest, rape or for a pregnancy which, as certified by a Physician, places you in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed.
24. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.
25. Any services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain., unless otherwise covered under the custom molded foot orthotic benefit.
26. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
27. Any services or supplies provided for the following treatment modalities:
    a. Acupuncture;
    b. Acupressure;
    c. Intersegmental traction;
    d. Surface EMGs;
    e. Spinal manipulation under anesthesia; and
    f. Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
28. Any items that include, but are not limited to, splints or bandages provided by a Physician in a non-hospital setting or purchased "over the counter" for support of strains and sprains, orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

Note: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment or custom molded foot orthotics listed as a covered medical expense.

29. Any benefits in excess of any specified dollar, day/visit, Calendar or Plan Year maximums.
30. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.
31. Repair and maintenance or replacement of Durable Medical Equipment unless identified as an eligible Benefit.
32. Private duty nursing services, except for medically necessary approved inpatient services.
33. Any Covered Drugs for which benefits are available under the Pharmacy Benefits Plan.
34. Any non-evidence based services or supplies provided for reduction mammoplasty.
35. Any nonprescription contraceptive medications or devices for male use.
36. Self-administered drugs dispensed or administered by a Physician in his/her office.
37. Biofeedback or other behavior modification services.
38. Any related services to a noncovered service. Related services are:
    a. Services in preparation for the noncovered service;
    b. Services in connection with providing the noncovered service;

c. Hospitalization required to perform the noncovered service; or

d. Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

39. Any services or supplies from more than one Provider on the same day(s) to the extent benefits were duplicated.
40. Residential Treatment Centers for Substance Use Disorder that are not:
    a. Affiliated with a Hospital under a contractual agreement with an established system for patient Referral;
    b. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals;
    c. Licensed as a Substance Use Disorder treatment program by the Texas Commission on Alcohol and Drug Abuse; or
    d. Licensed, certified or approved as a Substance Use Disorder treatment program or center by any other state agency having legal authority to so license, certify or approve.
41. Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for Covered Services provided by appropriate Providers as described in this Benefit Booklet.
42. Any of the following Applied Behavior Analysis (ABA) services;
    a. Services with a primary diagnosis that is not Autism Spectrum Disorder;
    b. Services that are facilitated by a Provider that is not properly credentialed. Please see the definition of Qualified ABA Provider in the **DEFINITIONS** section of this Benefit Booklet;
    c. Activities primarily of an educational nature;
    d. Respite, shadow, or companion services; or
    e. Any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.
43. For Treatment of any Injury or Illness for which you are not under the regular care of a Physician or which does not follow the attending Physician's treatment plan.
44. For Treatment of any Injury, Illness, or disability resulting from or sustained as a result of being engaged in a felonious act or transaction as defined by Texas and/or Federal law regardless of whether arrested, indicted, or convicted. This exclusion will apply when the felonious act or transaction is proven by a preponderance of the evidence.
45. For Treatment of injuries resulting from your participation in a riot or insurrection.
46. Prophylactic procedures and/or testing due to family history, unless otherwise specifically covered under the Plan.
47. For vocational evaluation, rehabilitation, or retraining.
48. For drug testing services that are not Evidence-Based Medicine (EBM) or standard of practice;
49. For Home Health Care expenses that are for:
    a. Custodial Care;
    b. Transportation services; or
    c. Any period during which you are not under the continuing care of a Physician.
50. For sex therapy, Outpatient group family therapy, marriage counseling, or any other social services unless otherwise specified.
51. For services and/or medications related to gender, sex, and/or intersex reassignment surgery (transsexual services) including any complications.
52. For personal comfort, convenience, or safety items; including but not limited to, the purchase or rental of telephones; televisions; guest meals or cots; orthopedic mattresses; allergy-free pillows, blankets, and/or mattress covers; non-hospital adjustable beds; waterbeds; structural changes to a house including tub rails and fixed shower benches; purchase, rental, or modification of motorized transportation equipment, manual or electronic lifts, elevators; escalators, and ramps.
53. For air purification, humidifying, cooling, or heating equipment.
54. For exercising equipment, vibratory equipment, swimming or therapy pools, health club memberships, massage therapy, or hippotherapy.
55. For spinography or thermography.
56. For any drug therapy, Treatment, or procedures meeting the definition of an Unproven Medical Procedure as defined in this booklet.
57. For cosmetic hair loss treatment.
58. For drugs labeled: "Caution - limited by Federal law to investigational use" or experimental drugs.
59. For claims submitted by the Employee or provider after the Filing Deadline.
60. For Cryotherapy machine to deliver cold therapy for home use.
61. For Treatment of conditions specifically excluded by the Plan and for Treatment of conditions Incurred as a result of, or due to complications of, a non-covered expense whether medically eligible or not. This exclusion does not apply to Pregnancy that is connected with the Treatment of infertility and assisted reproductive technology including but not limited to artificial, in-vitro, embryo transfer and insemination, or any surgical procedure for the inducement of Pregnancy.
62. For Employer-mandated immunizations, medical services, and medical testing.

63. For virtual colonoscopies.
64. For take home infusion pumps for intralesional administration of narcotic analgesics and anesthetics and intra-articular administration of narcotic analgesics and anesthetics.
65. For Treatment of any Injury or Illness during any extension of the time period of COBRA* which is attributable to the Employer's failure under the law or as required by contract to give timely notice of a Qualifying Event.
66. For Treatment of any Injury or Illness during any time period following a lump sum or severance settlement of an employment termination unless COBRA* has been elected and then only for the time period required by law under COBRA*.
67. For expenses that exceed (in scope, duration, or intensity) that level of care which is needed.
68. For services, medication, devices, and supplies that are utilized solely for the accreditation of the facility; or
69. Genetic/Genomic Testing is not eligible for sole purpose of diagnosing without approval through preauthorization. Genetic/Genomic Testing utilized for Treatment is eligible.
70. For any services incurred after the termination of coverage including any services incurred during an inpatient hospitalization that began while covered.
71. Care for conditions that federal, state, or local law requires to be treated in a public facility.
72. Appearances at court hearings and other legal proceedings, and any services relating to judicial or administrative proceedings or conducted as part of medical research.
73. The following psychological/neuropsychological testing and psychotherapy services:
    a. Educational testing;
    b. Employer/government mandated testing;
    c. Testing to determine eligibility for disability benefits;
    d. Testing for legal purposes (e.g., custody/placement evaluations, forensic evaluations, and court mandated testing);
    e. Testing for vocational purposes (e.g., interest inventories, work related inventories, and career development);
    f. Services directed at enhancing one's personality or lifestyle;
    g. Vocational or religious counseling;
    h. Activities primarily of an educational nature;
    i. Music or dance therapy; or
    j. Bioenergetic therapy.
74. Replacement for loss, damage or functional defect of hearing aids. Batteries are not covered unless needed at the time of the initial placement of the hearing aid devices.
75. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

** An Employee's right to COBRA coverage is subject to Federal law. Please see the COBRA Notice for more information.*

DEFINITIONS

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

ACCIDENTAL INJURY

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

ACTIVELY-AT-WORK EMPLOYEE

An employee who works and is paid by an employer for at least twenty (20) hours per week or as defined by said Employer. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on leave as defined by the Employer's leave policy, including but not limited to accessing vacation, sick, personal, paid time off, paid/unpaid Family Medical Leave Act of 1993 (FMLA), sick leave pool, unpaid approved leave, catastrophic leave, emergency leave, or short term disability leave, provided that Contributions to the Plan for such Employee continue to be paid on a timely basis.

In order for any form of leave that is not accrued on a weekly, monthly, annual, or other periodic basis to be considered as vacation, sick, personal, or paid time off leave under the previous paragraph, Employer's leave policy must be (1) in writing, (2) provided to TML Health upon request, and (3) available uniformly to all Employees. The non-accruing leave referred to herein shall include, but not be limited to: sick pool leave, catastrophic leave, disability leave, non-FMLA medical leave, Workers' Compensation Injury leave, and emergency leave. In order for compensatory time to be considered as hours actively at work, the Employer's compensatory policy must be (1) in writing, (2) on file with us prior to the start of the Employer's plan year, (3) available uniformly to all Employees, (4) clearly documented on each payroll document, and (5) in compliance with U.S. Department of Labor requirements.

Employees that do not meet the definition of an Actively-At-Work Employee in the Plan booklet are not eligible for medical Benefits.

An FMLA certification shall extend the period of coverage for Actively-At-Work Employee(s) when the FMLA documentation is provided in writing to us within thirty (30) days of the certification and one hundred and twenty (120) days of the beginning date of the FMLA leave.

ADOLESCENT DEPENDENT

An individual thirteen (13) to attained age of eighteen (18) years of age whose disabilities of minority have not been removed by marriage or judicial decree.

ALLOWABLE AMOUNT

The allowable Amount means the maximum amount determined by Claim Administrator to be eligible for consideration of payment for a Covered Service in accordance with the type of medical and dental benefits coverage(s) elected.

For Medical Covered Services. The Allowable Amount means:

1. For Network Providers. For a Provider who has a written agreement with Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Network Provider"), the contracting Allowable Amount is based on the terms of the Network Provider's contract and the payment methodology in effect on the date of the Covered Service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
2. For Non-Network Providers. For a Provider who does not have a written agreement with Claim Administrator or another Blue Cross and/or Blue Shield Plan to provide care to a Covered Person at the time Covered Services for medical benefits are rendered ("Non-Network Provider"), the Allowable Amount will be the lesser of:
    a. The Non-Network Provider's Claim Charge, or;
    b. Claim Administrator's Non-Contracting Allowable Amount. Except as otherwise provided in this section ii number 3, the Non-Contracting Allowable Amount is developed from base Medicare reimbursements adjusted by a predetermined factor established by Claim Administrator. Such factor shall be not less than seventy five percent (75%) and will exclude any Medicare adjustment(s) which is/are based on information on the Claim, or,
    c. Services for Ambulance, Emergency Medicine, Lab, Pathology, and DME are covered at 200% of CMS.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on a Claim, the non-contracting Allowable Amount for Non-

Network Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by Claim Administrator. Such factor shall be not less than seventy five percent (75%) and shall be updated not less than every two years.

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

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

The non-contracting Allowable Amount does not equate to the Provider's Claim Charge and Covered Persons receiving Covered Services from a Non-Network Provider will be responsible for the difference between the non-contracting Allowable Amount and the Non-Network Provider's Claim Charge, and this difference may be considerable. To find out Claim Administrator's non-contracting Allowable Amount for a particular Covered Service, Covered Persons may call customer service at the number on the back of Claim Administrator-issued identification card.

1. **For multiple surgeries** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.
2. **For procedures, services, or supplies provided to Medicare recipients** – The Allowable Amount will not exceed Medicare's limiting charge.

AMBULATORY SURGICAL CENTER (ASC)

A distinct entity that operates exclusively for the purpose of furnishing Outpatient surgical services to patients. An ASC is either independent or operated by a Hospital (i.e. under the common ownership, licensure, or control of a Hospital and/or Physician), and must be licensed and/or either Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) accredited, Accreditation Association for Ambulatory Healthcare (AAAHC) accredited, or accredited by another organization and/or Medicare approved to operate as an Ambulatory Surgery Center.

AMENDMENT

A formal document adopted by the Board of Trustees changing the provisions of the Plan. Amendments apply to all Employees, including those persons who are covered before the Amendment becomes effective, unless otherwise specified.

AQUATIC THERAPY

Services prescribed and performed by a licensed practitioner to restore, keep, learn, or improve skills and functions for daily living.

APPLIED BEHAVIOR ANALYSIS (ABA) THERAPY

A process of applying interventions that are based on the principles of learning to systematically teach new skills and generalize behaviors to new environments or situations.

AUTISM SPECTRUM DISORDER (ASD)

A neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder not otherwise specified. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

BEHAVIORAL HEALTH PRACTITIONER

A Physician or Professional Other Provider who renders services for Mental Healthcare, Serious Mental Illness or Chemical Dependency (SUD), only as listed in this Benefit Booklet.

BENEFIT

The amount payable by the Plan for Eligible Benefits.

BIRTHING CENTER

A free-standing facility licensed to provide for normal labor and delivery and that employs either a staff obstetrician or certified Nurse Midwife with an obstetrician consultant.

BOARD OF TRUSTEES

Our governing body as established by Section 172 of the Local Government Code.

CALENDAR YEAR

The period commencing on a January 1 and ending on the next succeeding December 31, inclusive.

CARDIAC REHABILITATION

A program of clinically supervised exercise designed to strengthen the heart and improve cardiovascular functioning. A Cardiac Rehabilitation program is designed for patients who have experienced a serious cardiac event and whose recovery would benefit from cardiovascular exercise, but the Employee cannot currently engage in unsupervised exercise without a clear risk to their health.

CHEMICAL DEPENDENCY

The abuse of or psychological or physical dependence on or addiction to alcohol or a Controlled Substance. Also referred to in this Benefit Booklet as substance use disorder (SUD).

CHEMICAL DEPENDENCY TREATMENT CENTER

A facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Behavioral Health Practitioner and which facility is also:

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

CHILD

The term "Child" means:

1. Your natural Child who is under twenty-six (26) years of age;
2. Your legally adopted Child (including a Child placed with you for adoption) who is under twenty-six (26) years of age;
3. Your stepchild who is under twenty-six (26) years of age;
4. Your foster Child placed in your care by the State, who is under twenty-six (26) years of age;
5. Your Child under twenty-six (26) years of age for whom you or your Spouse is legal guardian or conservator;
6. Your Child under twenty-six (26) years of age for whom a divorce decree or court order requires you or your Spouse to provide healthcare coverage for the Child;
7. Your Child age twenty-six (26) or older, provided the Child is totally disabled or incapacitated, see Incapacitated Child; or
8. Your grandchild whose naturally born or legally adopted parent is an eligible Child/Dependent. The term "grandchild" means a person who is a naturally born or legally adopted Child of your naturally born or legally adopted Child/Dependent. A grandchild who is covered by the Plan must be considered as your Dependent for support pursuant to federal income tax law. The grandchild will be eligible until your Child/Dependent attains age twenty-six (26).

CLINICAL ECOLOGY

The inpatient or outpatient diagnosis or treatment of allergic symptoms by:

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

CLINICAL TRIALS

Clinical Trials are controlled scientific studies designed to assess the effectiveness of procedures, drugs, and devices. Typically, Clinical Trials are performed after a Treatment shows promise during limited testing.

1. **Phase I Trials** – Medical researchers test the drug with a small group of people to discover its metabolic and pharmacologic actions in humans, as well as its safety, dosage, and side effects. They also test the impact of increasing doses and early evidence of effectiveness. This trial may include healthy participants or patients.
2. **Phase II Trials** – This stage is a controlled clinical study that evaluates the effectiveness of the drug for a particular indication or indications in patients with the condition under study. During this stage, researchers test the new drug with a slightly larger group of people (100 to 300) to collect more information about its common short-term side effects, efficacy, and risks.
3. **Phase III Trials** – The third stage expands controlled and uncontrolled trials after preliminary evidence suggests the effectiveness of the drug has been determined. Its purpose is to gather more information to evaluate the overall risk/benefit of the drug and provide a satisfactory basis for Physician labeling. Researchers give the drug to an even bigger group (between 1000 to 3000 people), monitor its use, compare it to other Treatments, and further ensure its safety.
4. **Phase IV Trials** – Post-marketing studies to identify additional uses for a U.S. Food and Drug Administration (FDA) approved medication. The studies also identify the drug's risks, benefits, and optimal use.
5. **Well-Conducted Clinical Trials** – Trials in which two or more Treatments are compared to each other, and the patient or provider is not allowed to choose which Treatment is received.

COINSURANCE
The percentage of costs of covered healthcare services you pay (20%, for example) after you have paid your Deductible.

COMMUNITY REINTEGRATION SERVICES
Services that facilitate the continuum of care as an affected individual transitions into the community.

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

CONFINEMENT
Recognized as Treatment in an Inpatient setting accessing Inpatient care.

CONTRACT ANNIVERSARY
The corresponding date in each year after the Contract Date for as long as the Contract is in force.

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

CONTRIBUTION
The amount payable by the Employer, the amount payable by the Employee, or the amount payable by the Employer and Employee jointly for participation in the Eligible Benefits of the Plan.

COORDINATION OF BENEFITS
A provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their Benefits so that the combined benefits of all plans do not exceed total allowable expenses.

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

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

CRISIS STABILIZATION UNIT OR FACILITY
An institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Healthcare and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

CRYOTHERAPY
Cold therapy used to reduce pain and swelling after an injury or surgery.

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

DAY TREATMENT
A Mental Health or Chemical Dependency/SUD Treatment Facility that meets all of the following requirements:
1. Provides Treatment for individuals suffering from acute Mental Health disorders and/or Chemical Dependency SUD in a structured program using individual treatment plans with specific attainable goals and objectives appropriate for the Employee;
2. Clinically supervised by a Physician who is certified in psychiatry by the American Board of Psychiatry and Neurology; and

3. Accredited by the Program for Mental Health Facilities and licensed by the JCAHO, or is a community health center, health center, or Day Treatment center which furnishes health services subject to the approval of the Department of Mental Health.

DEDUCTIBLE ELIGIBLE BENEFITS

Deductible Eligible Benefits in a given Calendar or Plan Year, which are the responsibility of the Employee before Benefits become payable by the Plan. If you are on a Qualified High Deductible/Health Savings Account (HSA) plan and are covering any Dependents, refer to your SBC to find out if your Plan has an individual Deductible for each member of the family, or a family Deductible that must be met in full before the Plan will pay. In the case of a family Deductible Plan, if any individual on the Plan meets the Federal Individual Maximum Out-of-Pocket Amount, the plan will begin to pay for In-Network services for that person.

DENTIST

Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is licensed to practice dentistry.

DEPENDENT

The Spouse or Dependent of an Employee who is eligible for Benefits under the Plan. A Spouse or Dependent who does not meet the definition of Spouse or Dependent in this benefit booklet is not eligible for medical Benefits.

We may request written proof of the eligibility of any Dependent and/or Spouse. For example, we may request a copy of a Child's birth certificate or a copy of a divorce decree. These requests are to verify eligibility and to determine if the Plan is primary or secondary.

DEVELOPMENTAL DELAY

A delay in achieving skills and abilities usually mastered by children of the same age. Delays may occur in any of the following areas: physical, social, educational, emotional, intellectual, speech and language, and/or adaptive development, sometimes called self-help skills, which include, but not limited to, dressing, toileting, feeding.

DIETARY AND NUTRITIONAL SERVICES

The education, counseling, or training of a Participant (including printed material) regarding:

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

DURABLE MEDICAL EQUIPMENT (DME)

Equipment that is eligible and appropriate only in the treatment or management of an Illness or Injury and is accepted in the medical community as safe and effective. Standard model items refer to the base model without added options and/or accessories.

DURABLE MEDICAL EQUIPMENT PROVIDER

A Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

ELIGIBLE BENEFITS

The Reasonable and Customary fees charged for medical service and supplies covered by the Plan and that are generally furnished for cases of comparable nature and severity in the particular geographical area where Incurred. Any agreement as to fees or charges made between the individual and the doctor shall not bind the Plan in determining its liability with respect to expenses Incurred. Expenses are Incurred on the date which the service or supply is rendered or obtained. The Employee also must have an obligation to pay the expense.

EMERGENCY CARE

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

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

EMPLOYEE

A general term that includes, but is not limited to, Actively-At-Work Employees, elected officials, and pre sixty-five Retirees of Pool Members who are eligible and/or have enrolled in the Plan. For the purpose of this definition, elected officials and employees of affiliated service contractors and economic development corporations are defined as an employee.

EMPLOYER

An eligible entity under Section 172 of the Local Government Code that is a member of TML Health.

ENROLL

To make written application for coverage on the prescribed forms or through an online enrollment system. Enrollment is not completed until accepted by the Employer and received by us within required timelines.

EVIDENCE-BASED MEDICINE (EBM)

Aims to apply the best available evidence gained from the scientific method to medical decision making. It seeks to assess the quality of evidence of the risks and benefits of Treatments (including lack of treatment). EBM recognizes that many aspects of medical care depend on individual factors such as quality and value of life judgements, which are only partially subject to scientific methods. EBM, however, seeks to clarify those parts of medical practice that are in principle subject to scientific methods and to apply these methods to ensure the best prediction of outcomes in medical Treatment, even as debate continues about which outcomes are desirable.

EXCLUSIONS

Those charges for which Benefits are not provided. Such charges are listed in "General Exclusions or Limitations."

EXPERIMENTAL/INVESTIGATIONAL

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

APPROVAL BY A FEDERAL AGENCY

The treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by BCBSTX in assessing Experimental/Investigational status but will not be determinative.

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

STANDARD MEDICAL TREATMENT

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

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

The medical staff of BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination.

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

EXTENDED CARE EXPENSES

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

EXTENUATING CIRCUMSTANCES

If an Employee requires care from a specialist care provider, but there is not an In-Network specialist care provider within a seventy-five (75) mile radius from the Employee's home, the provider would be paid as In-Network Benefits subject to Reasonable and Customary allowable amounts.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

FMLA provides eligible Employees up to twelve (12) workweeks (continual and/or intermittent) of unpaid leave a year if they have worked 1,250 hours during the twelve (12) months prior to the start of leave, and requires group health benefits to be maintained during the leave as if the Employee continued to work instead of taking leave. Employees are also entitled to return to their same or equivalent job at the end of their FMLA leave. The FMLA also provides certain military family leave entitlements. Eligible Employees may take FMLA leave for specified reasons related to certain military deployments of their family members. Additionally, they may take up to twenty-six (26) weeks of FMLA leave in a single twelve (12) month period to care for a covered service member with a serious injury or illness.

FILING DEADLINE

The Filing Deadline is the latest date a claim may be received by us in order to be considered eligible for payment.

An In-Network provider is required to file a claim according to their BCBSTX provider contract. If a claim is not filed timely per the terms of their contract, the claim will be denied, and the patient will not be responsible for any ineligible charges. For Out-of-Network providers, the Plan's Filing Deadline is twelve (12) months from the date the expense was Incurred.

An exception may be granted if it was not reasonably possible, as determined by us, to furnish the information within the Filing Deadlines, or within ninety (90) days after a non-compensable claim decision is made by the Employer's Workers' Compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance.

FULL MEDICARE COVERAGE

Full Medicare Coverage is coverage under both Part A (Hospital Insurance) and Part B (Medical Insurance), and/or Part C (HMO/Advantage Insurance). If you are eligible to enroll in Part A, you will be deemed to have Full Medicare Coverage, even if you have not Enrolled in Part B, Part C, and/or Part D.

GENETIC TESTING

The examination of a single gene or subset of genes from human DNA for an anomaly associated with a disease or disorder. DNA is taken from a sample of your blood, body fluid, or tissue.

GENOMIC TESTING

The examination of the complete genome (all genes from human DNA of one patient) for any genetic anomaly associated with a disease or disorder. DNA is taken from a sample of your blood, body fluid, or tissue.

HABILITATIVE SERVICES

Habilitative services means skilled, Medically Necessary, healthcare 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. The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain your current condition or to prevent or slow further decline.
2. It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing, or transferring from a bed to a chair.
3. It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general wellbeing or condition in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

LIMITATIONS AND EXCLUSIONS

1. Coverage is excluded for services that are solely educational or vocational in nature or otherwise paid under state or federal law for purely educational services. A service that does not help you to meet or maintain functional goals in a treatment plan within a prescribed timeframe is not a habilitative service.
2. Coverage is excluded when the patient does not meet criteria for coverage as indicated in the Indications for Coverage section above and enrollee specific benefit document.
3. Coverage is excluded if the service is considered by us to be unproven, investigational, or experimental.
4. Coverage is excluded for Custodial Care, respite care, day care, therapeutic recreation vocational training, and residential treatment.
5. In the absence of a disabling condition, services to improve general physical condition are excluded from coverage.
6. Coverage is excluded once the treatment plan goals are met.
7. Coverage is excluded for physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter. An example includes, but is not limited to, the same day combined use of hot packs, ultrasound, and iontophoresis in the treatment of strain.
8. Coverage is excluded for programs that do not require the supervision of Physician and/or a licensed therapy provider.
9. Coverage is excluded for Work Hardening.
10. Coverage is excluded for Confinement, Treatment, services or supplies that are required: a) only by a court of law, or b) only for insurance, travel, employment, and school or camp purposes.
11. Coverage is excluded for services beyond any visit limits specified in the enrollee specific benefit document.
12. Coverage is excluded for gym and fitness club memberships and fees, health club fees, and exercise equipment or supplies.
13. Biofeedback services are excluded.

HEALTH BENEFIT PLAN

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

1. Accident only or disability income insurance, or a combination of accident-only and disability income insurance;
2. Credit-only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long-term care coverage or benefits, Home Health Care coverage or benefits, nursing home care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited-scope dental or vision benefits;

9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
    a. Contain a plan of benefits for employees,
    b. Are negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
    c. Are authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis;
16. Short-term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
    a. Similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
    b. Specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

HEALTHCARE 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.

HEALTH INSURANCE MARKETPLACE

Health insurance market plan through the Affordable Care Act's Health Insurance Marketplace, www.HealthCare.gov.

HEALTH STATUS RELATED FACTOR

1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of healthcare;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of family violence; and
8. Disability.

HIPAA

Federal law referred to as the Health Insurance Portability and Accountability Act of 1996. HIPAA went into effect for most group health plans on the anniversary that occurred on or after July 1, 1997. HIPAA provides individuals certain rights and protections relating to healthcare coverage.

HOME HEALTH AGENCY

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

HOME HEALTH CARE

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

HOME INFUSION THERAPY

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

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

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

HOME INFUSION THERAPY PROVIDER

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

HOSPICE

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

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

HOSPICE CARE

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

HOSPITAL

A short-term acute care facility which:

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

HOSPITAL ADMISSION

The period between the time of a Participant's entry into a Hospital or a Chemical Dependency 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

Confinement in a bed accommodation of a Chemical Dependency 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 Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

HUMANITARIAN USE DEVICE (HUD)

The coverage determination on a HUD will be made according to the hierarchy of evidence applied towards the evaluation of any technology, in the same way the evaluation would be applied to a service or technology that is FDA approved without a Humanitarian Device Exemption.

If the device is determined to be proven for the use it should be covered; if the device is determined to be unproven for use, then it should not be covered.

IDENTIFICATION CARD

The card issued to the Employee by BCBSTX indicating pertinent information applicable to his coverage.

ILLNESS

Sickness or disease which requires Treatment by a licensed Healthcare Provider.

IMAGING CENTER

A Provider that can furnish technical or total services with respect to diagnostic services and is licensed by an agency of the state of Texas having legal authority to so license, certify or approve.

INCAPACITATED CHILD

A Dependent Child age twenty-six (26) or older who is mentally or physically incapable of supporting himself/herself and is primarily dependent upon you for financial support. We may require satisfactory proof of the continued incapacity documented as a disability by the Social Security Administration (SSA). We may have a Physician examine the Child or may request proof to confirm the incapacity, but not more often than once a year. If you fail to submit proof when reasonably required or refuse to allow us to have the Child examined, then coverage for the Child will terminate.

INCURRED

The date on which a service is rendered or a supply is obtained.

INDEPENDENT LABORATORY

A Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

IN-NETWORK BENEFITS

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

INPATIENT HOSPITAL EXPENSE

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

1. Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided by a Hospital or a Chemical Dependency Treatment Center; and
3. Furnished to and used by the Participant during an inpatient Hospital Admission.

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

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semi-private 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 Healthcare or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, a Residential Treatment Center, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

INTENSIVE OUTPATIENT PROGRAM

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

INTENSIVE CARE UNIT

A section, ward, or wing within a Hospital which is operated exclusively for critically ill patients and provides special supplies, equipment, and constant observation and care by Nurses. This definition includes neonatal care, coronary care, pulmonary/respiratory, and other special care units.

INTENSIVE OUTPATIENT THERAPY

Outpatient Mental Health or Substance Use Disorder Treatment of high frequency over a short period of time.

LIFE-THREATENING DISEASE OR CONDITION

For the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

LONG TERM ACUTE CARE (LTAC) FACILITY

A long-term acute care Hospital that provides extended, intensive medical care to patients who are clinically complex and suffering from multiple acute or chronic conditions. Such patients typically require a longer than usual Hospital stay because of the severity of Illness or the chronic nature of the disease process.

MAINTENANCE CARE

All services, equipment, and supplies which are provided solely to maintain your condition and from which no functional improvement can be expected.

MARRIAGE AND FAMILY THERAPY

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

MATERNITY CARE

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

MAXIMUM OUT-OF-POCKET AMOUNT

The most you will pay for covered services in a Calendar or Plan Year. After you spend this amount on Deductibles, Copayments, and Coinsurance, the plan will pay 100% of the cost of covered Benefits.

MEDICALLY JUSTIFIED

A service that falls under the Plan definition of Unproven Medical Procedures/Therapy, but that can be justified for an individual patient due to:

1. A rare/orphan disease (a rare/orphan disease is one that affects fewer than 200,000 people, according to the U.S. Rare Disease Act of 2002);
2. A unique comorbidity, or complication that precludes treatment with a proven medical procedure or therapy;
    a. No other Treatment available due to comorbidities;
    b. Comorbid Disease State Risk;
3. Continuation and/or repeat of a previously approved successful treatment plan;
4. Concern for complications due to treatment area;
5. Repeat of prior successful Treatment intervention and disease state; disease state put in remission;
6. Treatment dose in compliance for best outcome;
7. Severity of Illness defined as ongoing intensity and complication of disease state with lab value concerns.

MEDICAL SOCIAL SERVICES

Those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to assessment of the:

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

MEDICAL-SURGICAL EXPENSES

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

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

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

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

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

MEDICALLY NECESSARY OR MEDICAL NECESSITY

Those services or supplies covered under the Plan which are:

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

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

MEDICARE

A federal health insurance program for people aged sixty-five (65) or older, and certain disabled individuals, provided by Title XVIII of the Social Security Act, as amended.

MEDICARE SECONDARY REPORTING REQUIREMENTS

Eligibility information will be securely and electronically submitted to Medicare regarding all Employees.

MENTAL HEALTHCARE

Any one or more of the following:

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

MENTAL HEALTH TREATMENT FACILITY

A facility constituted and operated under law which includes all of the following:

1. Is accredited as a Hospital under the Hospital Accreditation Program of the JCAHO;
2. Maintains permanent and full-time facilities for care of five (5) or more patients;

3. Provides a program for diagnosis, evaluation, and effective treatment of Mental Health conditions;
4. Complies with all licensing and other legal requirements;
5. Has a Physician, RN, and a medical staff responsible for execution of all policies and procedures;
6. Provides twenty-four (24) hour skilled nursing care by Nurses under the supervision of an RN;
7. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. Has an established protocol for medical emergencies; and
9. Is not, other than incidentally, a place for Custodial Care or for care of the aged and senile.

IN-NETWORK

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

IN-NETWORK PROVIDER

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

NON-ACCREDITED MORBID OBESITY TREATMENT CENTER

A facility not designated as a Blue Distinction or Blue Distinction Centers+ for Bariatric Surgery by BlueCross Blue Shield.

NON-CONTRACTING FACILITY

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

NURSE

An RN, Licensed Vocational Nurse (LVN), Licensed Practical Nurse (LPN), Advanced Nurse Practitioner (ANP), or Registered Nurse First Assistant (RNFA).

NURSE MIDWIFE/CERTIFIED PROFESSIONAL MIDWIFE (CPM)

A licensed RN who is certified as a Nurse Midwife by the American College of Nurse-Midwives and is authorized to practice as a Nurse Midwife under state regulations.

A CPM who is a knowledgeable, skilled, and professionally independent midwifery practitioner and has met the standards for certification set forth by the North American Registry of Midwives (NARM). Graduate programs must be accredited by the Midwifery Education and Accreditation Council (MEAC) or certified by the American Midwifery Certification Board (AMCB) as a CNM/CM.

OPEN ENROLLMENT PERIOD

The thirty (30) or thirty-one (31) day period preceding the next Plan year during which Employees and Dependents may enroll for coverage. Coverage will become effective on the first day of the new plan year.

OTHER PROVIDER

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

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

s. Nurse First Assistant

t. Physician Assistant

u. Psychological Associates who work under the supervision of a Doctor in Psychology

The listings shown, above, in 1. and 2., unless otherwise defined in the Plan, shall have the meaning assigned to them by the Texas Insurance Code. In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

OUT-OF-NETWORK BENEFITS

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

OUT-OF-NETWORK PROVIDER

A Hospital, Physician, Behavioral Health Practitioner or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

OUTPATIENT

Treatment or Confinement in a medical facility where you have not been admitted as an Inpatient.

OUTPATIENT CONTRACEPTIVE SERVICES

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

OUTPATIENT OBSERVATION

Treatment or Confinement in a medical facility with the purpose of observing you to determine the need for further Outpatient Treatment or for Inpatient admission.

PARTICIPANT

An Employee or Dependent whose coverage has become effective under this Contract.

PHARMACY BENEFIT MANAGER

The Plan's prescription carrier.

PHYSICAL MEDICINE SERVICES

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

PHYSICIAN

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

PLAN

The provisions for coverage and payment of Benefits as described in this booklet. This is an incurrence of expense plan that excludes payment for any service of any type Incurred before coverage begins or after coverage ends.

PLAN ADMINISTRATOR

TML Health has been designated to serve as the Plan Administrator.

PLAN SERVICE AREA

The geographical area or areas specified in the Contract in which a Network of Providers is offered and available and is used to determine eligibility for Managed Healthcare Plan benefits.

PLAN SPONSOR

For the purpose of this Plan booklet, TML Health or Administrative Services Only (ASO) Employer, as applicable.

PREAUTHORIZATION

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

PRE-DETERMINATION

Process of reviewing provider-submitted clinical information supporting the eligibility of a planned procedure/Treatment or device(s). A Pre-determination is done in advance of a procedure/Treatment or device(s) and is subject to Plan Benefits and limitations.

PRIMARY CARE COPAYMENT AMOUNT

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

PROMPT PAY

Provider contractual or statutory requirement that assesses penalties for failure for contractual/regulatory timely claim payment.

PROOF OF LOSS

Written evidence of a claim including:

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

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

PROSTHETICS/ORTHOTICS PROVIDER
A certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

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

QUALIFIED ABA PROVIDER
A Provider operating within the scope of their license or certification that has met the following requirements:

For the treatment supervisor/case manager/facilitator:

1. Healthcare Practitioner, who is licensed, certified, or registered by an appropriate agency in the state where services are being provided, or
2. Healthcare Practitioner whose professional credential is recognized and accepted by an appropriate agency of the United States, (i.e. Board-Certified Behavior Analyst (BCBA) or Board-Certified Behavior Analyst-Doctoral (BCBA-D), or
3. Healthcare Practitioner who is certified as a provider under the TRICARE military health system.

For the para-professional/line therapist:

1. Two years of college educated staff person with a Board Certified Assistant Behavior Analyst (BCABA) for the para-professional/therapist, or
2. A staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist effective as of January 1, 2019.

REHABILITATIVE HOSPITAL
An institution constituted and operated under law which:

1. Is primarily engaged in providing rehabilitation services for sick or injured persons and meets the definition of a Hospital; and
2. Is not, other than incidentally, a place for Custodial Care, for care of the aged or senile, for Treatment of Mental Health or Substance Use Disorder, or a school or similar institution.

RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS
An accredited child care institution that provides residential care and Treatment for emotionally disturbed children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation (COA), the JCAHO, or the American Association of Psychiatric Services for Children (AAPSC).

REMEDIATION
The process(es) of restoring or improving a specific function.

RENAL DIALYSIS CENTER
A facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

RESEARCH INSTITUTION
An institution or Provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

RESIDENTIAL TREATMENT CENTER
A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, and structure and is licensed by the appropriate state and local authority to provide such service. It does not include halfway houses, wilderness programs, supervised living, group homes, boarding houses, or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour onsite nursing service for Mental Healthcare and/or for treatment of Chemical Dependency. BCBSTX requires that any facility providing Mental Healthcare and/or a Chemical Dependency Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by BCBSTX as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS
A child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Healthcare and Serious Mental Illness services for emotionally disturbed children and adolescents.

RESPONSIBLE THIRD-PARTY
Any of the following:

1. A responsible third-party individually;

2. A responsible third-party insurance company (whether contribution-funded or self-funded) including, but not limited to Payments received under the following types of policies: premises, automobile, homeowners, professional, DRAM shop, or any other applicable liability or excess insurance policy;
3. An Employee's own underinsured/uninsured automobile insurance coverage regardless of the source;
4. Any underinsured/uninsured automobile insurance coverage that provides benefits to an Employee;
5. No fault insurance coverage, such as personal injury or medical payments protection regardless of the source;
6. Any award, settlement or benefit paid under any workers' compensation law, claim, or award;
7. Any indemnity agreement or contract;
8. Any other payment designated, delineated, earmarked, or intended to be paid to an Employee as compensation, restitution, remuneration for Injuries sustained or Illness suffered as a result of the negligence or liability, including contractual, of any individual or entity; and/or
9. Any source that reimburses, arranges, or pays for the cost of the type of damages covered by the Eligible Benefits of this Plan, including, but not limited to, recovery for the cost of medical expenses

RETAIL HEALTH CLINIC

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

RETIREE

An employee who has ceased active, Benefit-eligible employment with the Employer and meets the Employer's guidelines to qualify as a Retiree and draws all other applicable Retiree Benefits.

RIGHT OF SUBROGATION

The right of TML Health to recover amounts paid for Benefits on your behalf when a third party may be liable or legally responsible for expenses Incurred by you for an Illness, sickness, or bodily Injury.

ROUTINE PATIENT CARE COSTS

The costs of any Medically Necessary healthcare service for which benefits are provided under the Plan, without regard to whether the Participant is participating in a clinical trial.

Routine patient care costs do not include:

1. The investigational item, device, or service itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

SERIOUS MENTAL ILLNESS

The following psychiatric illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

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

SKILLED NURSING FACILITY

An institution or a distinct part of an institution which meets all of the following criteria:

1. Is primarily engaged in providing for Inpatient skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;
2. Has policies which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one (1) or more Physicians and one (1) or more RNs, to govern the skilled nursing care and related medical care or other services provided;
3. Has a Physician, an RN, and a medical staff responsible for the execution of such policies;
4. Has a requirement that the healthcare of every patient must be under the supervision of a Physician and provides for having a Physician available to furnish necessary medical care in case of emergency;
5. Maintains clinical records on all patients;
6. If required, provides twenty-four (24) hour nursing care under the supervision of an RN;
7. Provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;
8. Has in place a utilization review plan which provides for the review of admissions to the institution, the duration of stays, and the professional services furnished with respect to eligibility;
9. Is licensed by the appropriate state or local agency; and
10. Is Medicare or Medicaid eligible.

A skilled nursing facility meets the definition of an extended care facility but does not include any institution which is primarily for Custodial Care or for care of the aged or senile.

SKILLED NURSING SERVICES
Nursing services performed by an RN, LVN, or LPN for health services.

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

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

SPECIALTY DRUG
A drug classified as high-cost, high complexity and/or high touch. Specialty Drugs are often biologics (drugs derived from living cells), that are injectable or infused (although some are oral medications). They are used to treat complex or rare chronic conditions.

SPOUSE
Individual legally married to you under the laws of any state. We may request written proof of the spousal relationship, such as a copy of the marriage certificate. Proof of a properly filed declaration of informal marriage is required for an informal marriage to be recognized by the Plan.

SUBSTANCE USE DISORDER
Habituation, abuse, and/or addiction to alcohol or other chemical substance not including nicotine. This includes physiological and/or psychological dependence.

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 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 healthcare service delivered by a Physician or Behavioral Health Practitioner licensed in Texas, or a health professional acting under the delegation and supervision of a Physician or Behavioral Health Practitioner licensed in Texas, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

THERAPEUTIC CENTER
An institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

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

TRANSPLANT
The removal and replacement of human tissue and/or organ.

TREATMENT
Any specific procedure or service used for the cure or improvement of an Illness, disorder, or Injury.

UNITED STATES PREVENTIVE SERVICES TASK FORCE (USPSTF)
The U.S. Preventive Services Task Force is an independent, volunteer panel of national experts in disease prevention and Evidence-Based Medicine (EBM). The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services.

VIRTUAL PROVIDER
A licensed Provider that has entered into a contractual agreement with BCBSTX to provide diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology), or (ii) interactive audio/video examination and communication (via online portal, mobile application, or similar technology).

VIRTUAL VISITS
Services provided for the treatment of non-emergency medical and behavioral health conditions as described in Benefits for Virtual Visits provision.

WAITING PERIOD
A required period of time before coverage becomes effective. Waiting Periods must not be in excess of ninety (90) days. A thirty (30) day bona fide employment-based orientation period may be added to the ninety (90) day Waiting Period limitation. Check with your Employer to determine your Waiting Period.

WORK HARDENING
Work Hardening is an interdisciplinary program consisting of physical therapy, Occupational Therapy, and counseling professionals for injured workers or other adults whose injuries or disease processes interfere with their ability to work. It provides structured Treatment designed to progressively improve physical function as a transition between acute care and return to work.

GENERAL PROVISIONS

AGENT
The Employer is not the agent of the Carrier.

AMENDMENTS
The Plan may be amended or changed at any time by agreement between the Employer and TML Health. If TML Health makes any material modification in any of the terms of the plan or coverage that would affect the content of the Summary of Benefits and Coverage (SBC) (a document that summarizes plan benefits, cost sharing, and limitations, as required under the Affordable Care Act), that is not reflected in the most recently provided SBC, and that occurs other than in connection with a renewal or reissuance of coverage, TML Health will provide notice of the modification to Participants not later than 60 days prior to the date on which the modification will become effective.

ASSIGNMENT AND PAYMENT OF BENEFITS
If a written assignment of benefits is made by a Participant to a Provider and the written assignment is delivered to BCBSTX with the claim for benefits, BCBSTX will make any payment directly to the Provider. Payment to the Provider discharges the BCBSTX's responsibility to Participant for any benefits available under the Plan.

CONFORMITY WITH STATE STATUTES
Laws in some states require that certain benefits or provisions be provided to you if you are a resident of that state when the contract that insured you is not issued in your state. Any provision of this Benefit Booklet which, on its effective date, is in conflict with applicable statutes of the state in which the Employee resides on such date, is hereby amended to conform to: (a) the minimum requirements of such statutes, or (b) the benefits or provisions of this Benefit Booklet to the extent they exceed such minimum requirements.

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

ENTIRE PLAN
This Plan, any attachments, amendments, the Administrative Services Agreement, and the individual applications, if any, of Subscribers constitute the entire agreement between the parties and as of the effective date hereof, supersede all other agreements between the parties.

FORCE MAJEURE
In the event that due to circumstances not within the commercially reasonable control of the Claim Administrator, the rendering of professional or Hospital Services provided under this Plan is delayed or rendered impractical, the Claim Administrator shall make a good faith effort to arrange for an alternative method of providing coverage. These circumstances may include, but are not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of the Participating Providers' personnel or similar causes. In such event, Participating Providers shall render the Hospital and Professional Services provided for under the Plan insofar as practical, and according to their best judgment; but the Claim Administrator and Participating Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

FORM OR CONTENT OF PLAN
No agent or employee of the Claim Administrator is authorized to change the form or content of this Plan except to make necessary and proper insertions in blank spaces. Changes can be made only through endorsement authorized and signed by an officer of the Claim Administrator. No agent or other person, except an authorized officer of the Claim Administrator, has authority to waive any conditions or restrictions of this Plan, to extend the time for making a payment, or to bind the Claim Administrator by making any promise or representation or by giving or receiving any information.

IDENTITY THEFT PROTECTION
As a Participant, BCBSTX makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by BCBSTX's

designated outside vendor and acceptance or declination of these services is optional to the Participant. Participants who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbstx.com or telephonically by calling the Customer Service Helpline. Services may automatically end when the person is no longer an eligible Participant. Services may change or be discontinued at any time with reasonable notice. BCBSTX does not guarantee that a particular vendor or service will be available at any given time.

COORDINATION WITH MEDICARE

Medicare is a federal health insurance program for people aged sixty-five (65) or older, and certain disabled individuals, provided by Title XVIII of the Social Security Act, as amended.

Full Medicare Coverage is coverage under both Part A (Hospital Insurance) and Part B (Medical Insurance), and/or Part C (HMO/Advantage Insurance). If you are entitled to premium-free Part A, you will be deemed to have Full Medicare Coverage, even if you have not Enrolled in Part B, Part C, and/or Part D.

Who will pay first or primary usually depends on work status of the Employee regardless of how many persons the Employer may employ.

Status	Age	Primary Plan
Retired	65+	Medicare
Spouse of Retiree	65+	Medicare
Spouse of Retiree	<65	Employer
Active	65+	Employer
Spouse of Active EE	65+	Employer
Spouse of Active EE	<65	Employer

There are special rules for people with permanent kidney failure and persons under sixty-five (65) who have Medicare because of a disability.

If the Plan is primary, the normal Benefits payable under the Plan will be paid without regard to Medicare. If Medicare is primary, the combined total payable by full Medicare coverage and the Plan will not exceed the normal Benefit payable by the Plan.

If Medicare coverage is due to End Stage Renal Disease, the order of payment shall be determined by applicable federal regulations.

TML Health will determine which plan is primary. The determination is based, among other things, on your status on the date expenses are Incurred.

Even if an Employee does not Enroll for Full Medicare Coverage or make due claim for Medicare Benefits, we will calculate the Benefits which would have been paid by Full Medicare Coverage and adjust the Plan Benefits payable accordingly to the Medicare allowed amount.

In cases where a provider has opted out of Medicare where neither the provider nor the beneficiary receives any reimbursement from Medicare, we will calculate the Benefits which would have been paid by Medicare coverage (see table above), according to the Medicare allowed amount.

We submit electronic eligibility information to Medicare as required by law and secondary payor regulations.

NEW MEDICAL TECHNOLOGY

BCBSTX keeps abreast of medical breakthroughs, experimental treatments and newly approved medication. The medical policy department evaluates new technologies, medical procedures, drugs and devices for potential inclusion in the benefit packages we offer. Clinical literature and accepted medical practice standards are assessed thoroughly with ongoing reviews and determinations made by our Medical Policy Group.

PARTICIPANT/PROVIDER RELATIONSHIP

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

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

REFUND OF BENEFIT PAYMENTS

If your group's benefit plan or BCBSTX pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been,

or was made in error ("Overpayment"), your group's Plan and BCBSTX have the right to obtain a refund of the Overpayment 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 group's benefit Plan and/or BCBSTX (in its capacity as insurer or administrator) have 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 BCBSTX-administered ASO benefit program and/or BCBSTX-administered insured benefit program or policy; or,
3. Any future benefit payment made to any person or entity under another BCBSTX-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 payment owed to one or more Participating Providers or Out-of-Network Providers.

Further, BCBSTX has the right to reduce your benefit Plan's or policy's payment to a provider by the amount necessary to recover another BCBSTX plan's or policy's overpayment to the same provider and to remit the recovered amount to the other BCBSTX plan or policy.

STATE GOVERNMENT PROGRAMS

1. If a Participant under the Plan is also a Medicaid recipient, any benefits for services or supplies under the Plan will not be excluded solely because benefits are paid or payable for such services or supplies under Medicaid. Any benefits available under the Plan will be payable to the Texas Department of Human Services to the extent required by the Texas Insurance Code; and
2. All benefits paid on behalf of a child or children under the Plan must be paid to the Texas Department of Human Services where;
    a. The Texas Department of Human Services is paying benefits pursuant to provisions in the Human Resources Code; and
    b. The parent who is covered under the Plan has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and
    c. BCBSTX receives written notice at its Administrative Office affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.

THIRD PARTY LIABILITY

Definitions

This section applies if you are injured in an accident or become ill through the act or omission of another person, company, or business and recover money from any source. "Payments" as used in this section shall mean the proceeds of any payment, settlement, judgement, or other remuneration paid by any person or entity other than under the Plan. "Responsible Third Party" as used in this section shall mean any person who is alleged to have caused or contributed in any way to causing the harm for which recovery of damages is sought.

Right of Subrogation

If the Plan has paid eligible Benefits on your behalf, for expenses related to an Illness or Injury caused by an act or omission of a Responsible Third Party, and you receive Payments from the Responsible Third Party related to that Illness or Injury, the Plan is subrogated to all of your rights of recovery, meaning the Plan must be paid back 100% of what it paid on your behalf for the related medical expenses.

Right of Recovery

If the Plan provides a Benefit for an Employee that exceeds the amount that should have been paid, the Plan may require that the overpayment be returned when requested, or reduce a future Benefit payment for you or your Dependent by the amount of the overpayment. In short, if we paid when we shouldn't have, we have the right to be paid back.

Assignment

If we have paid healthcare expenses related to Employee's Illness or Injury caused by a Responsible Third Party, the Employee's claim against that Responsible Third Party is assigned to us. No Employee may assign, waive, compromise, or settle any rights or causes of action, without our written consent.

Reimbursement

We have the right to be reimbursed for the Eligible Benefits provided to an Employee. If an Employee does not reimburse us from the Payments, we are entitled to reduce current or future Eligible Benefits payable to or on behalf of that Employee until we are fully reimbursed.

Plan's Actions

To protect our interest, we may, among other things: place a lien on a Responsible Third Party or Employee; file a lawsuit on our own or on an Employee's behalf; and/or cease payment for Eligible Benefits. An Employee's failure to cooperate with the Plan is considered a violation of the Plan. We have the right to: terminate Eligible Benefits, deny future Eligible Benefits, take legal action against an Employee, and/or set off from any future Eligible Benefits. You agree to include the

Plan's name as a co-payee on all Payments from Responsible Parties. The fact that we do not assert or invoke these rights until after your settlement or other disposition of a dispute, or you have received Payments as full or partial satisfaction of your losses, shall not relieve you of your obligation to reimburse us in full.

Obligations of the Employee to the Plan

If you may have a claim against a third party (including any insurance company) as a result of Illness or Injury, you must:

1. Advise us immediately;
2. Fill out and submit an Accident/Injury Questionnaire and fully cooperate with us to provide information regarding your Illness or Injury (including anticipated future Treatment related to the Injury/Illness);
3. Produce all documentation requested, including medical authorizations, correspondence, demands, reports, and insurance adjuster information, non-privileged litigation documents, and/or any other documentation provided to or received from Responsible Third Parties;
4. Fully cooperate with the Plan in the prosecution of a claim;
5. Agree on behalf of yourself and on behalf of any minor Children to allow us to obtain and share your medical information, necessary to investigate, pursue, sue, compromise, and/or settle the above-described claims;
6. Obtain consent of the Plan before settling any claim or suit, including relating to any non-medical elements of damages, or releasing any party from liability for our payment of medical expenses resulting from your Injury or Illness; and
7. Hold any Payment you receive as a result of your Injury or Illness from any Responsible Third Party in trust for our benefit until we have been repaid.

Nothing in these provisions requires us to pursue your claim against any Responsible Third Party.

Miscellaneous

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein. The Plan's rights of subrogation, lien, recovery, assignment, or reimbursement as set forth herein will not be affected, reduced, or eliminated by the "made whole doctrine" and/or any other equitable doctrine or law which requires that the Employee be "made whole" before the Plan is reimbursed. The Plan will not be responsible for any expenses, fees, costs, or other monies incurred by the attorney for the Employee and/or his or her beneficiaries. In the event that any section of these provisions is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of the Plan. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the plan. The rights expressed in this document in favor of the Plan are cumulative and do not exclude any other rights or remedies available at law or in equity to the Plan or anyone connected with the Plan.

Wrongful Death/Survivorship Claims

In the event that the Employee dies as a result of his or her Injuries and a wrongful death or survivorship claim is asserted, the Employee's obligations become the obligations of the Employee's wrongful death beneficiaries, heirs, and estate.

Non-Exclusive Rights

By Enrolling in the Plan, you agree to abide by the provisions in one (1) through nine (9) following this paragraph. We may suspend payment of claims for the Injury or Illness based on the amount of the claim, indication of other insurance, indication there may be another source to pay for the medical services required as a result of the Injury or Illness, or evidence that the claim may not be covered because it is work-related.

As an additional assurance, payment of the claim(s), and future claims relating to the Injury or Illness will only resume if you:

1. Provide any and all information requested by us;
2. Agree in writing not to settle damages whether by legal action, settlement, or otherwise until after consulting with us to determine the full and potential medical charges;
3. Agree that should you settle for damages as a result of an Injury/Illness with a Responsible Third Party, prior to securing such written permission, we are relieved of any liability for medical Benefits now or in the future resulting from the Injury/Illness;
4. Agree that we may provide any medical bills or payment information related to the Injury/Illness to your attorney, any insurer, or any other person who will be reimbursing us for medical Benefits;
5. Agree in writing to reimburse us immediately upon collection of damages whether by legal action, settlement, or otherwise including, but not limited to, uninsured motorist, underinsured motorist, no-fault, personal injury protection, or medical payments coverage that is in the name of, paid for, or payable by you or a non-immediate family member;
6. Agree in writing that venue for all subrogation disputes shall be in Travis County, Texas;
7. Agree in writing to provide us with a copy of any settlement agreement relating to this Injury/Illness if requested;
8. Agree to cooperate fully with us in asserting our rights. This means you must supply us with all information and sign and return all documents reasonably necessary to carry out our right to recover from the Responsible Third Party any Benefits paid under the Plan which are subject to this provision; and

9. Agree in writing to all provisions of the Plan.

Automobile/Homeowners Liability and/or Medical Payments Insurance Benefits

Benefits payable under the Plan may be adjusted by us for any insurance benefits available for medical benefits, including no-fault, medical payments, personal injury protection, or uninsured motorist coverage if the coverage for such medical benefits is in the name of, paid for, or payable by a non-immediate family member whether or not any party has admitted liability.

VALUE BASED DESIGN PROGRAMS

This Plan has the right to offer medical management programs, quality improvement programs, and health behavior wellness, incentive, maintenance, or improvement programs that allow for a reward, a contribution, a differential in premiums, a differential in medical, prescription drug or equipment Copayments, Coinsurance, Deductibles or costs, or a combination of these incentives or disincentives for participation in any such program offered or administered by this Plan or an entity chosen by this Plan to administer such program. In addition, discount or incentive programs for various health or wellness-related, insurance-related or other items and services may be available from time to time. Such programs may be discontinued without notice.

Individuals in wellness programs who are unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, this Plan will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact this Plan for additional information regarding any value based programs offered by this Plan.

COORDINATION OF BENEFITS

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

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

Allowable Expense

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

Healthcare Plan

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

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

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

nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

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

BCBSTX has the right to coordinate benefits between this Healthcare Plan and any other Healthcare Plan covering you.

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

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

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

1. **Nondependent or Dependent.** The Healthcare Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the Healthcare Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Healthcare Plan covering the person as a dependent and primary to the Healthcare Plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the Healthcare Plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Healthcare Plan is the primary plan. An example includes a retired employee.
2. **Dependent Child Covered Under More Than One Healthcare Plan**. Unless there is a court order stating otherwise, Healthcare Plans covering a Dependent child must determine the order of benefits using the following rules that apply.
    a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
        i. The Healthcare Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
        ii. If both parents have the same birthday, the Healthcare Plan that has covered the parent the longest is the primary plan.
    b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
        i. If a court order states that one of the parents is responsible for the Dependent child's healthcare expenses or healthcare coverage and the Healthcare Plan of that parent has actual knowledge of those terms, that Healthcare Plan is primary. This rule applies to plan years commencing after the Healthcare Plan is given notice of the court decree.
        ii. If a court order states that both parents are responsible for the Dependent child's healthcare expenses or healthcare coverage, the provisions of 2.a. must determine the order of benefits.
        iii. If a court order states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent child, the provisions of 2.a. must determine the order of benefits.
        iv. If there is no court order allocating responsibility for the Dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
            I. The Healthcare Plan covering the custodial parent;
            II. The Healthcare Plan covering the spouse of the custodial parent;
            III. The Healthcare Plan covering the noncustodial parent; then
            IV. The Healthcare Plan covering the spouse of the noncustodial parent.
    c. For a Dependent child covered under more than one Healthcare Plan of individuals who are not the parents of the child, the provisions of 2.a or 2.b. must determine the order of benefits as if those individuals were the parents of the child.
    d. For a Dependent child who has coverage under either or both parents' Healthcare Plans and has his or her own coverage as a Dependent under a spouse's Healthcare Plan, paragraph 5. below applies.
    e. In the event the Dependent child's coverage under the spouse's Healthcare Plan began on the same date as the Dependent child's coverage under either or both parents' Healthcare Plans, the order of benefits must be determined by applying the birthday rule in 2.a. to the Dependent child's parent(s) and the Dependent's spouse.
3. **Active, Retired, or Laid-off Employee.** The Healthcare Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Healthcare Plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the Healthcare Plan that covers the same person as a retired or laid-off employee or as a Dependent of a retired or laid-off employee does not have this rule, and as a result, the Healthcare Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

4. **COBRA* or State Continuation Coverage.** If a person whose coverage is provided under COBRA* or under a right of continuation provided by state or other federal law is covered under another Healthcare Plan, the Healthcare Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA*, state, or other federal continuation coverage is the secondary plan. If the other Healthcare Plan does not have this rule, and as a result, the Healthcare Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The Healthcare Plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the Healthcare Plan that has covered the person the shorter period is the secondary plan.
6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the Healthcare Plans meeting the definition of Healthcare Plan. In addition, this Healthcare Plan will not pay more than it would have paid had it been the primary plan.

When this Healthcare Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Healthcare Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under its Healthcare Plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Healthcare Plans for the claim equal 100 percent of the total Allowable Expense for that claim. In addition, the secondary plan must credit to its plan deductible (if applicable) any amounts it would have credited to its deductible in the absence of other healthcare coverage.

If a covered person is enrolled in two or more closed panel Healthcare Plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel Healthcare Plan, COB must not apply between that Healthcare Plan and other closed panel Healthcare Plans.

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

None of the above rules as to coordination of benefits shall delay your health services covered under this Plan.

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

TERMINATION OF COVERAGE

The Plan excludes payments for any service of any type Incurred after coverage ends. For information concerning your right to continuation of medical coverage, please refer to the COBRA* Notice. Once a Retiree moves to COBRA* and COBRA* terminates, the Retiree is not eligible for our Retiree Benefits.

Coverage under the Plan will terminate for you and/or your Dependent(s) on the earliest of:

1. The end of the month your employment terminates;
2. The end of the month in which you cease to be an Actively-At-Work Employee;
3. The end of the month in which you are no longer eligible for coverage;
4. The date the group Benefit Plan terminates coverage with the Employer;
5. The date your Employer is no longer participating under the Plan;
6. The date your Dependent becomes enrolled in Medicaid;
7. The end of the month in which your Dependent Child attains age twenty-six (26), unless your Dependent Child is physically or mentally incapacitated;
8. The end of the month Dependent coverage is voluntarily dropped pursuant to a Qualifying Event as prescribed by the Internal Revenue Service regulations, provided we receive written notice within thirty-one (31) days of the event;
9. The end of the month in which the retiree coverage is voluntarily dropped; or
10. Failure to pay for coverage.

** An Employee's right to COBRA coverage is subject to Federal law. Please see the COBRA Notice for more information.*

Coverage for a Dependent cannot extend beyond the date coverage for you ends, unless required by Section 615.071, Texas Government Code (Tex. Gov't Code) for survivors of certain Employees as described in Section 615.003, Tex. Gov't Code who are killed in the line of duty. Section 615.075(c), Tex. Gov't Code requires that the survivor must give the Employer notice of election to purchase coverage within one hundred eighty (180) days of the decedent's death.

Dropping Dependent Coverage

The following events may affect Dependent coverage. You are required to notify us within thirty-one (31) days of the below events:

1. Marriage;
2. Sixty (60) days of the birth, adoption, or placement for adoption of a Child;
3. Divorce of the Employee; or
4. Death of the Employee.

You must notify your Employer if you wish to voluntarily drop Dependent coverage. Any drop of a Dependent regardless of whether the coverage is paid for pursuant to pre-tax or post-tax payroll deduction will only be allowed following a Qualifying Event as prescribed by the Internal Revenue Service regulations and on these conditions:

1. Any change in coverage must be consistent with the Qualifying Event; and
2. Once a Dependent has been dropped, he or she cannot be added to the Plan until the next Open Enrollment period or a Qualifying Event occurs. Forms for reporting these changes are available from the Employer.

RESCISSION OF COVERAGE

Rescission of coverage is the cancellation or discontinuance of coverage retroactive to previous date. For example, cancellation of your coverage back to the effective date because you did not meet eligibility requirements of the Plan is a rescission.

The Plan will not rescind your or the Employer's coverage except in the case of fraud, or intentional misrepresentation of material fact, or failure to pay for coverage. If the Plan does rescind coverage, we will send a notice to affected individuals at least thirty (30) days prior to rescinding the coverage.

TERMINATION OF THE GROUP

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

EXTENSION OF BENEFITS

If this Contract terminates (as described in the Employer's Contract), any Participant who is Totally Disabled on the effective date of the termination of the Contract shall be entitled to receive benefits as described in this Benefit Booklet, subject to the benefit limitations and maximums, for the continued treatment of the condition causing the Total Disability. Benefits will be available for the period of the Total Disability or for 90 days following the termination date of the Contract, whichever is less.

However, if your coverage under the Plan is replaced with coverage issued by a Succeeding Carrier which provides substantially equivalent or greater benefits than those provided by this Contract, this extension of benefits for Total Disability is not applicable.

SUCCEEDING CARRIER

An insurer that has replaced the coverage of TML Health with its coverage.

TOTAL DISABILITY OR TOTALLY DISABLED

Means as applied to:

1. An Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of his occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned prior to disability; and
2. A Dependent, confinement as a bed patient in a Hospital.

REQUIRED NOTICES

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

Out-of-Area Services

Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, herein called BCBSTX has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "InterPlan Programs." Whenever you obtain healthcare services outside of the BCBSTX service area, the claims for these services may be processed through one of these InterPlan Programs, which include the BlueCard Program, and may include negotiated National Account arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

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

A. BlueCard® Program

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

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

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

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

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

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

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

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

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

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

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

2. **Exceptions:** In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion negotiate a payment with such Non-Participating Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:
    a. The amount calculated using the methodology described in the Certificate for Non-Participating Providers located inside your service area (and described in Section C(1) above); or
    b. The following:
        i. For Professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Certificate for Non-Participating Providers located inside your service area; or an amount based on publicly available provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or
        ii. For Hospital or facility Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Certificate for Non-Participating Providers located inside your service area; or an amount based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

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

D. Inter-Plan Programs: Federal/State Taxes Surcharges/Fees

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

E. Special Cases: Value-Based Programs

BlueCard® Program

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

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

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

F. Blue Cross Blue Shield Global Core

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

If you need medical assistance services (including locating a doctor or hospital) outside the Blue Card service area, you should call the service center at (800) 810-BLUE (2583) or call collect at (804) 673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

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

   Physicians, urgent care centers, and other outpatient providers located outside the Blue Card service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for covered healthcare services.
3. **Submitting a Blue Cross Blue Shield Global Core Claim:** When you pay for covered healthcare services outside the Blue Card service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSTX, the service center or online at www.bcbsglobalcore.com If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

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

This notice is to advise you of certain coverage and/or benefits provided by your contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation. Please note that many Texas Department of Insurance mandatory benefits do not apply to TML Health. The ones listed below, however, do apply:

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

1. A physical examination for the detection of prostate cancer; and
2. A prostate-specific antigen test for each covered male who is:
    a. At least 50 years of age; or
    b. At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of: (a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or (b) a colonoscopy performed every 10 years.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No.1210-0149
expires 5/31/2020

PART A

General Information

When key parts of the healthcare law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate 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.

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 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

NOTE: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often 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 your employer, please check your SBC or contact TML Health Customer Care at (800) 282-5385.

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

[1] *An Employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.*

PART B

This section contains information about any health coverage offered by your employer. 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.

3. Employer Name	4. Employer Identification Number (EIN)	
5. Employer Address	6. Employer Phone Number	
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone Number (if different than above)	12. Email Address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:

    _____
  - ☐ Some employees. Eligible employees are:

    _____
- With respect to dependents:
  - ☐ We do offer coverage. Eligible Dependents are:

    _____
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

***Even if your Employer intends your coverage to be affordable, 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, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.*

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

- Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____(mm/dd/yyyy) (Continue)

- No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

- Yes (Go to question 15)
- No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $_____

_____

b. How often?

- ☐ Weekly
- ☐ Every 2 weeks
- ☐ Twice a month
- ☐ Monthly
- ☐ Quarterly
- ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $_____

_____

b. How often?

- ☐ Weekly
- ☐ Every 2 weeks
- ☐ Twice a month
- ☐ Monthly
- ☐ Quarterly
- ☐ Yearly

**An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)*

Medicare Prescription Creditable Coverage Notice

Certificate of Group Health Plan Coverage

1. Date of this certificate: _____
2. Name of group health plan: _____
3. Name of participant: _____
4. UID: _____
5. Name of individuals to whom this certificate applies:

_____

6. Name, address, and telephone number of Plan Administrator or issuer responsible for providing this certificate: TML Health, PO Box 149190, Austin, Texas 78714-9190, (512) 719-6500
7. For further information, call: (800) 282-5385
8. If the individual(s) identified in line 5 has (have) at least eighteen (18) months of creditable coverage (disregarding periods of coverage before a sixty-three (63) day break), check here and skip lines 9 and 10: _____
9. Date Waiting Period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: «Date_Coverage_Ended»; or check if coverage is continuing as of the date of this certificate: _____

TML Health will furnish separate certificates if information is not identical for the covered Employee and each Dependent.

Statement of HIPAA Portability Rights

Important – Keep this Certificate. This certificate is evidence of your coverage under the TML Health plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a pre-existing condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage if you have health problems.

Be Aware - HIPAA's portability rights apply to most, but not all group health plans. HIPAA requires TML Health to include with this certificate the following educational information on HIPAA's portability rights. However, HIPAA's portability rights do not apply to TML Health plans; and the rights described below do not apply to individuals Enrolled in, or wanting to Enroll in, a TML Health plan.

Pre-existing Condition Exclusions

Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "pre-existing condition exclusions." A pre-existing condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the six months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a Waiting Period, the first day of your Waiting Period (typically, your first day of work). In addition, a pre-existing condition exclusion cannot last for more than twelve (12) months after your enrollment date (eighteen (18) months if you are a late enrollee). Finally, a pre-existing condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within thirty (30) days after birth, adoption, or placement for adoption.

If a plan imposes a pre-existing condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for sixty-three (63) days or more without coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a sixty-three (63) day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any pre-existing condition exclusion if you enroll in another plan.

Right to Get Special Enrollment in Another Plan

Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within thirty (30) days. Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.

1. Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition Against Discrimination Based on a Health Factor

Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to Individual Health Coverage

Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a pre-existing condition exclusion. To be an eligible individual, you must meet the following requirements:

1. You have had coverage for at least eighteen (18) months without a break in coverage of sixty-three (63) days or more;
2. Your most recent coverage was under a group health plan (which can be shown by this certificate);
3. Your group coverage was not terminated because of fraud or nonpayment of premiums;
4. You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
5. You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

1. Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a sixty-three (63) day break.

State Flexibility

This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For More Information

If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at (866) 444-3272 (for free HIPAA publications ask for publications concerning changes in healthcare laws). You may also contact the CMS publication hotline at (800) 633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: dol.gov/ebsa, the DOL's interactive web pages – Health Elaws, or cms.gov.

Medicare Prescription Non-Creditable Coverage Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage through TML Health 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two (2) important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium;
2. TML Health has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, NOT expected to pay as much as the standard Medicare prescription drug coverage pays (due to the high deductible). Therefore, your prescription drug coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you have prescription drug coverage through TML Health. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

You can keep your current coverage through TML Health. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on whether and when you join a Medicare drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully — it explains your options.

When can you join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you decide to drop your current coverage through TML Health, since it is employer-sponsored

group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage through TML Health.

When will you pay a higher premium (penalty) to join a Medicare Drug Plan?

Since the coverage through TML Health is not creditable, depending on how long you go without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go sixty-three (63) continuous days or longer without prescription drug coverage that is creditable, 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 nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What happens to your current coverage if you decide to join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage through TML Health will be affected. If you join a Medicare drug plan, your TML Health prescription benefits will end. If you do decide to join a Medicare drug plan and drop your TML Health coverage, be aware that you and your Dependents will not be able to get the TML Health prescription coverage back.

For More Information

For more information about this notice or your current prescription drug coverage, call TML Health at (800) 282-5385.

Note: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if your coverage through TML Health changes. You may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage, read your "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. For more information about Medicare prescription drug coverage:

1. Visit www.medicare.gov;
2. Call your State Health Insurance Assistance Program for personalized help (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number);
3. Call 1-800-MEDICARE - (800) 633-4227 | TTY users should call (877) 486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call (800) 772-1213, TTY (800) 325-0778.

Special Enrollment Rights Notice

Para asistencia en español, llame al departamento de Servicio al Cliente 1-800-282-5385 quien la proveerá sevicios de traducción

For assistance for deaf and hard of hearing individuals, call 711 | Para personas con discapacidad auditiva, marque 711

If you do not enroll yourself or an eligible Dependent (including your Spouse) in TML Health's medical plan because you or your Dependent has other medical coverage, you may enroll in the TML Health medical plan at a later date if you or your Dependent loses coverage under the other medical plan. To enroll in TML Health's medical plan, the loss of other coverage must be due to loss of eligibility for coverage or because the employer who sponsors the other plan stops contributing toward the cost of your or your Dependent's coverage.

Also, you must request enrollment in TML Health's medical plan within thirty-one (31) days of the date your or your Dependent's other coverage ends. In general, only the person who loses other coverage may enroll in TML Health's medical plan as a result of this special enrollment opportunity. However, an Employee who declined enrollment in TML Health's medical plan when offered must enroll himself or herself at the same time he or she enrolls a Dependent.

If you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in TML Health's medical plan if you request enrollment within thirty-one (31) days of the date of the marriage, or within sixty (60) days of the birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

1. If you or a Dependent experiences a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP), you and your plan-eligible Dependents may be allowed to enroll in a TML Health plan if you request enrollment within sixty (60) days after the coverage with Medicaid or state CHIP ends.

2. If you or a Dependent becomes eligible for payment assistance with the cost of coverage under a TML Health medical plan through Medicaid or state CHIP, TML Health will allow you and your plan-eligible Dependents to enroll in a TML Health medical plan. You must request coverage within sixty (60) days of the date you or your Dependent becomes eligible for payment assistance.

To request special enrollment or for more information about special enrollment opportunities, call TML Health's Customer Care staff at (800) 282-5385.

Women's Health and Cancer Rights Act (WHCRA) Notice

TML Health's medical plan provides comprehensive benefits, including benefits for mastectomy and breast reconstruction. If you have a disease of the breast and mastectomy is the recognized necessary medical Treatment for that disease, TML Health covers eligible expenses for the mastectomy/lumpectomy and for any complications of the mastectomy, including lymphedema.

Eligible Benefits include the initial non-cosmetic removal and replacement of prosthetics due to complications. Reconstructive Surgery includes tissue expanders, breast implants, nipple reconstruction, and nipple tattooing.

Benefits for breast reconstruction are available even if your mastectomy was performed before you were covered under the TML Health medical plan. However, the mastectomy must have been performed because of a disease of the breast.

Eligible expenses for mastectomy and breast reconstruction are payable subject to the same Deductibles and Coinsurance that apply to other medical and surgical expenses covered by TML Health's medical plan. If you would like more information on benefits for mastectomy or breast reconstruction, call TML Health's Customer Care at (800) 282-5385.

Medicaid and Children's Health Insurance Program (CHIP) Notice

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 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 visit 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 sixty (60) days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your state for more information on eligibility.

STATE	CONTACT
ALABAMA Medicaid	**Website:** http://www.myalhipp.com **Phone:** 1-855-692-5447
ALASKA Medicaid	**The AK Health Insurance Premium Payment Program** **Website:** http://myakhipp.com **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility** **Website:** http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS Medicaid	**Website:** http://myarhipp.com **Phone:** 1-855-MyARHIPP (855-692-7447)

STATE	CONTACT
CALIFORNIA Medi Cal	**Website:** http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx **Phone:** 1-916-636-1980
COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**Health First Colorado** **Website:** https://www.healthfirstcolorado.com **Contact Center:** 1-800-221-3943/ State Relay 711 **CHP+** **Website:** http://www.colorado.gov/HCPF/Child-Health-Plan-Plus **Customer Service:** 1-800-359-1991/ State Relay 711
FLORIDA Medicaid	**Website:** http://flmedicaidtplrecovery.com/hipp **Phone:** 1-877-357-3268
GEORGIA Medicaid	**Website:** https://medicaid.georgia.gov/health-insurancepremium-payment-program-hipp **Phone:** 678-564-1162 ext 2131
INDIANA Medicaid	**Healthy Indiana Plan for low-income adults 19-64** **Website:** http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 **All other Medicaid** **Website:** http://www.indianamedicaid.com | Phone 1-800-403-0864
IOWA Medicaid & CHIP (Hawki)	**Medicaid** **Website:** http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp **Phone:** 1-888-346-9562 **Hawki** **Website:** http://dhs.iowa.gov/Hawki **Phone:** 1-800-257-8563
KANSAS Medicaid	**Website:** http://www.kdheks.gov/hcf **Phone:** 1-800-792-4884
KENTUCKY Medicaid	**Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)** **Website:** https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx **Phone:** 1-855-459-6328 **Email:** KIHIPP.PROGRAM@ky.gov **KCHIP** **Website:** https://kidshealth.ky.gov/Pages/index.aspx **Phone:** 1-877-524-4718 **Kentucky Medicaid** **Website:** https://chfs.ky.gov
LOUISIANA Medicaid	**Website:** www.medicaid.la.gov or www.ldh.la.gov/lahipp **Phone:** 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE Medicaid	**Website:** http://www.maine.gov/dhhs/ofi/public-assistance/index.html **Phone:** 1-800-442-6003 **TTY:** Maine relay 711
MASSACHUSETTS Medicaid and CHIP	**Website:** http://www.mass.gov/eohhs/gov/departments/masshealth **Phone:** 1-800-862-4840
MINNESOTA Medicaid	**Website:** http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp **Phone:** 1-800-657-3739

STATE	CONTACT
MISSOURI Medicaid	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005
MONTANA Medicaid	**Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084
NEBRASKA Medicaid	**Website:** http://www.ACCESSNebraska.ne.gov **Phone:** (855) 632-7633; **Lincoln:** (402) 473-7000; **Omaha:** (402) 595-1178
NEVADA Medicaid	**Medicaid** **Website:** https://dhcfp.nv.gov **Phone:** 1-800-992-0900
NEW HAMPSHIRE Medicaid	**Website:** https://www.dhhs.nh.gov/ombp/nhhpp/ **Phone:** 603-271-5218 **Hotline:** NH Medicaid Service Center at 1-888-901-4999
NEW JERSEY Medicaid and CHIP	**Medicaid** **Website:** http://www.state.nj.us/humanservices/dmahs/clients/medicaid **Phone:** 609-631-2392 **CHIP** **Website:** http://www.njfamilycare.org/index.html **Phone:** 1-800-701-0710
NEW YORK Medicaid	**Website:** https://www.health.ny.gov/health_care/medicaid **Phone:** 1-800-541-2831
NORTH CAROLINA Medicaid	**Website:** https://dma.ncdhhs.gov **Phone:** 919-855-4100
NORTH DAKOTA Medicaid	**Website:** http://www.nd.gov/dhs/services/medicalserv/medicaid **Phone:** 1-844-854-4825
OKLAHOMA Medicaid and CHIP	**Website:** http://www.insureoklahoma.org **Phone:** 1-888-365-3742
OREGON Medicaid	**Website:** http://healthcare.oregon.gov/Pages/index.aspx **Website:** http://www.oregonhealthcare.gov/index-es.html **Phone:** 1-800-699-9075
PENNSYLVANIA Medicaid	**Website:** https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx **Phone:** 1-800-692-7462
RHODE ISLAND Medicaid	**Website:** http://www.eohhs.ri.gov/ **Phone:** 855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA Medicaid	**Website:** https://www.scdhhs.gov **Phone:** 1-888-549-0820
SOUTH DAKOTA Medicaid	**Website:** http://dss.sd.gov **Phone:** 1-888-828-0059
TEXAS Medicaid	**Website:** http://gethipptexas.com/ **Phone:** 1-800-440-0493

STATE	CONTACT
UTAH Medicaid and CHIP	**Medicaid** **Website:** https://medicaid.utah.gov **CHIP** **Website:** http://health.utah.gov/chip **Phone:** 1-877-543-7669
VERMONT Medicaid	**Website:** http://www.greenmountaincare.org **Phone:** 1-800-250-8427
VIRGINIA Medicaid and CHIP	**Medicaid** **Website:** https://www.coverva.org/famis **Phone:** 1-804-786-7933 **CHIP** **Phone:** 1-855-242-8282
WASHINGTON Medicaid	**Website:** http://www.hca.wa.gov **Phone:** 1-800-562-3022 ext. 15473
WEST VIRGINIA Medicaid	**Website:** http://mywvhipp.com **Toll-free phone:** 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN Medicaid	**Website**: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf **Phone:** 1-800-362-3002
WYOMING Medicaid	**Website:** https://wyequalitycare.acs-inc.com/ **Phone:** 855-294-2127

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, you can contact either: *U.S. Department of Labor U.S. Department of Health and Human Services or Employee Benefits Security Administration Centers for Medicare & Medicaid Services*

www.dol.gov/agencies/ebsa | www.cms.hhs.gov | 1-866-444-EBSA (3272) | 1-877-267-2323, Menu Option 4, Ext. 61565

HIPAA Notice of Privacy Practices for Protected Health Information (PHI)

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

TML Health is required by law to keep your health information private and to notify you if TML Health, or one of its business associates, breaches the privacy or security of your unsecured, identifiable health information. This notice tells you about TML Health's legal duties connected to your health information. It also tells you how TML Health protects the privacy of your health information. As your group health plan, TML Health must use and share your health information to pay Benefits to you and your Healthcare Providers. TML Health has physical, electronic, and procedural safeguards that protect your health information from inappropriate or unnecessary use or sharing.

Is all my health information protected?

Your individually identifiable health information that TML Health transmits or maintains in writing, electronically, orally, or by any other means is protected. This includes information that TML Health creates or receives and that identifies you and relates to your participation in the health plan, your physical or mental health, your receipt of healthcare services, and payment for your healthcare services.

What steps does TML Health take to protect my information?

Because TML Health believes that protecting your health information is of the highest priority, TML Health takes the following steps to ensure that your health information remains confidential:

1. Business Associate Agreements - TML Health follows the requirements of federal law and makes sure that any TML Health business associate who receives your personal health information signs a written agreement to protect your health information.

2. Encryption of Health Data - TML Health encrypts your health information that is sent electronically (for example, over the Internet) so that no one who is not supposed to can view your health information. To make sure that only the people who need your health information to administer your health plan benefits are able to see it, TML Health reviews the list of people who are allowed to view your personal health information on a regular basis.
3. Independent Review - TML Health periodically employs an independent security company to review and test TML Health's security controls to make sure they meet the requirements of federal law. The independent security company provides certified security professionals to conduct the review.
4. Use of Health Information - TML Health's Privacy Officer reviews the use of personal health information by TML Health to ensure that it complies with both federal law and with TML Health's own privacy policies.

How does TML Health use and share my health information?

TML Health's most common use of health information is for its own treatment, payment, and healthcare operations. TML Health also may share your health information with Healthcare Providers, other health plans, and healthcare clearinghouses for their treatment, payment, and healthcare operations. (Healthcare clearinghouses are organizations that help with electronic claims.)

TML Health also may share your health information with a TML Health business associate if the business associate needs the information to perform treatment, payment, or healthcare operations on TML Health's behalf. For example, if your health plan includes a retail and mail order pharmacy network, TML Health must share information with the pharmacy network about your eligibility for Benefits. Healthcare Providers, other health plans, healthcare clearinghouses, and TML Health business associates are all required to maintain the privacy of any health information they receive from TML Health. TML Health uses and shares the smallest amount of your health information that it needs to administer your health plan.

What are treatment, payment, and healthcare operations?

1. Treatment is the provision, coordination, or management of healthcare and related services. For example, your health information is shared for treatment when your family doctor refers you to a specialist.
2. Payment includes TML Health activities such as billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review, and notification of healthcare services. For example, TML Health may tell a doctor if you are covered under a TML Health plan and what part of the doctor's bill TML Health will pay.
3. Healthcare operations include quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting, and other activities necessary to create or renew health plans. It also includes disease management, case management, conducting or arranging for medical review, legal services, auditing functions including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities. For example, TML Health may use information from your claims to contact you about treatment alternatives or other health-related benefits and services that may be of interest to you. Please note that while TML Health may use and share your health information for underwriting, TML Health is prohibited from using or sharing any of your genetic information for underwriting.

How else does TML Health share my health information?

TML Health may share your health information, when allowed or required by law, as follows:

1. Directly with you or your personal representative. A personal representative is a person who has legal authority to make healthcare decisions for you. In the case of a child under eighteen (18) years of age, the child's personal representative may be a parent, guardian, or conservator. In the case of an adult who cannot make his or her own medical decisions, a personal representative may be a person who has a medical power of attorney.
2. With the Secretary of the U.S. Department of Health and Human Services to investigate or determine TML Health's compliance with federal regulations on protecting the privacy and security of health information.
3. With your family member, other relative, close personal friend, or other person identified by you who is involved directly in your care. TML Health will limit the information shared to what is relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the release of your health information.
4. For public health activities.
5. To report suspected abuse, neglect, or domestic violence to public authorities.
6. To a public oversight agency.
7. When required for judicial or administrative proceedings.
8. When required for law enforcement purposes.

9. With organ procurement organizations or other organizations to facilitate organ, eye, or tissue donation or transplantation.
10. With a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties required by law.
11. With a funeral director when permitted by law and when necessary for the funeral director to carry out his duties with respect to the deceased person.
12. To avert a serious threat to health or safety.
13. For specialized government functions, as required by law.
14. When otherwise required by law.
15. Information that has been de-identified. This means that TML Health has removed all your identifying information and it is reasonable to believe that the organization receiving the information will not be able to identify you from the information it receives.

Can I keep TML Health from using or sharing my health information for any of these purposes?

You have the right to make a written request that TML Health not use or share your health information, unless the use or release of information is required by law. However, since TML Health uses and shares your health information only as necessary to administer your health plan, TML Health does not have to agree to your request.

Are there any other times when TML Health may use or share my health information?

TML Health may not use or share your health information for any purpose not included in this notice, unless TML Health first receives your written authorization. To be valid, your authorization must include: the name of the person or organization releasing your health information; the name of the person or organization receiving your health information; a description of your health information that may be shared; the reason for sharing your health information; and an end date or end event when the authorization will expire. You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before TML Health receives your request.

TML Health must always have your written authorization to:

1. Use or share psychotherapy notes, unless TML Health is using or sharing the psychotherapy notes to defend itself in a legal action or other proceeding brought by you.
2. Use or share your identifiable health information for marketing, except for: (1) a face-to-face communication from TML Health, or one its business associates, to you; or (2) a promotional gift of nominal value given by TML Health, or one of its business associates, to you.
3. Sell your identifiable health information to a third party.

Will TML Health share my health information with my Employer?

TML Health shares summary health information with the Employer who sponsors your group health plan. Employers need this information to get bids from other health plans or to make decisions to modify, amend, or terminate the TML Health group health plan. Summary health information summarizes the claims history, claims expenses, or type of claims experienced by the entire group of people covered under a health plan. Summary health information does not include any information that identifies you, such as your name, social security number, or date of birth.

Also, TML Health shares with the Employer who sponsors your group health plan information on whether you are enrolled in TML Health's group health plan or if you recently added, changed, or dropped coverage.

Can I find out if my health information has been shared with anyone?

You may make a written request to TML Health's Privacy Officer for a list of any disclosures of your health information made by TML Health during the last six (6) years. The list will not include any disclosures made for treatment, payment, or healthcare operations; any disclosures made directly to you; any disclosures made based upon your written authorization; or any disclosures reported on a previous list.

Generally, TML Health will send the list within sixty (60) days of the date TML Health receives your written request. However, TML Health is allowed an additional thirty (30) days if TML Health notifies you, in writing, of the reason for the delay and notifies you of the date by which you can expect the list.

If you request more than one list within a twelve (12) month period, TML Health may charge you a reasonable, cost-based fee for each additional list.

Can I view my health information maintained by TML Health?

You may make a written request to inspect, at TML Health's offices, your enrollment, payment, billing, claims, and case or care management records that TML Health maintains. You also may request paper copies of your records. If you request paper copies, TML Health may charge you a reasonable, cost-based fee for the copies.

Requests to view your health information should be made in writing to:

TML Health
ATTN: Privacy Officer
PO Box 149190, Austin, Texas 78714-9190

If I review my health information and find errors, how do I get my records corrected?

You may request that TML Health correct any of your health information that it creates and maintains. All requests for correction must be made to TML Health's Privacy Officer, must be in writing, and must include a reason for the correction.

Please be aware that TML Health can correct only the information that it creates. If your request is to correct information that TML Health did not create, TML Health will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be corrected because the diagnosis is incorrect, TML Health will correct the claim if TML Health made an error in the data entry of the diagnosis. However, if your Healthcare Provider submitted the wrong diagnosis to TML Health, TML Health cannot correct the claim without a statement from your Healthcare Provider that the diagnosis is incorrect.

TML Health has sixty (60) days after it receives your request to respond. If TML Health is not able to respond, it is allowed one (1) thirty (30) day extension. If TML Health denies your request, either in part or in whole, TML Health will send you a written explanation of its denial. You may then submit a written statement disagreeing with TML Health's denial and have that statement included in any future disclosures of the disputed information.

I'm covered as a Dependent and do not want any of my health information mailed to the Employee's address. Will you do that?

If mailing communications to the Employee's address would place you in danger, TML Health will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the Employee's address would place you in danger.

Please be aware that TML Health is required to send the Employee any payment for a claim that is not assigned to a Healthcare Provider, except under certain medical child support orders.

If I believe my privacy rights have been violated, how do I make a complaint?

If you believe your privacy rights have been violated, you may make a complaint to TML Health.

Write to:

TML Health, ATTN: Privacy Officer, PO Box 149190, Austin, Texas 78714-9190 or call: (800) 282-5385

Also, you may file a complaint with the U.S. Department of Health and Human Services. TML Health will not retaliate against you for filing a complaint.

When are the privacy practices described in this notice effective?

This privacy notice has an effective date of September 1, 2013.

Can TML Health change its privacy practices?

TML Health is required by law to follow the terms of its privacy notice currently in effect. TML Health reserves the right to change its privacy practices and to apply the changes to any health information TML Health received or maintained before the effective date of the change. TML Health will maintain its current privacy notice on its website at tmlhealthbenefits.org. If a revision is made during your plan year, TML Health will post the revised notice to its website on the date the new notice goes into effect. You will receive a paper copy of the revised privacy notice before the start of your next plan year.

What happens to my health information when I leave the plan?

TML Health is required to maintain your records for at least six (6) years after you leave TML Health's group health plan. However, TML Health will continue to maintain the privacy of your health information even after you leave the plan.

How can I get a paper copy of this notice?

To request that TML Health mail you a paper copy of this notice, call (800) 282-5385.

Who can I contact for more information on my privacy rights?

Write to:

TML Health, ATTN: Privacy Officer, PO Box 149190, Austin, Texas 78714-9190 or call:(800) 282-5385

Continuation Coverage Rights Under COBRA

*NOTE: Certain employers may not be affected by **CONTINUATION OF COVERAGE AFTER TERMINATION***

(COBRA). See your employer or Group Administrator should you have any questions about COBRA. Specifically, an Employer must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part-time employees employed, not the number of employees covered by a Health Benefit Plan.

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

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

Non-Discrimination Notices

English

TML Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TML Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

TML Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Civil Rights Coordinator using the contact information below

If you believe that TML Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Arabic

يلتزم TML Health Benefits بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو نوع الجنس. لا يستبعد TML Health Benefits الأشخاص أو يعاملهم على نحو مختلف بسبب النوع أو اللون أو الأصل الوطني أو السن أو الإعاقة أو نوع الجنس.

TML Health Benefits:

- يوفر مساعدات وخدمات مجانية للأشخاص من ذوي الإعاقات للتواصل بصورة فعالة معنا، مثل:
  - مترجمي لغة إشارة مؤهلين
  - معلومات كتابية بتنسيقات أخرى (مطبوعة بأحرف كبيرة، مواد صوتية، تنسيقات إلكترونية متيسرة، وغير ذلك من التنسيقات)
- يوفر خدمات لغوية مجانية للأشخاص الذين لغتهم الأساسية ليست الإنجليزية، مثل:
  - مترجمين مؤهلين
  - معلومات مكتوبة بلغات أخرى

إذا كنت بحاجة لهذه الخدمات، اتصل بـ Civil Rights Coordinator

إذا كنت تعتقد أن TML Health Benefits قد أخفق في توفير تلك الخدمات أو ميز بطريقة أخرى على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس، يمكن أن تتقدم بشكوى إلى: Civil Rights Coordinator - PO Box 149190, Austin, TX 78754-9190، 1-800-282-5385، TTY 711، 512-719-6539، CRCoordinator@tmlhb.org. يمكن أن تتقدم بشكوى شخصيًا أو بالبريد أو بالفاكس أو البريد الإلكتروني. إذا كنت بحاجة للمساعدة في التقدم بشكوى، فإن Civil Rights Coordinator متاح لمساعدتك.

يمكن أيضًا أن تتقدم بشكوى إلكترونيًا لوزارة Department of Health and Human Services (وزارة الخدمات الصحية والبشرية) ، مكتب Office for Civil Rights (مكتب الحقوق المدنية)، من خلال مكتب Office for Civil Rights Complaint Portal، المتوفر على الرابط https://ocrportal.hhs.gov/ocr/portal/lobby.jsf أو بالبريد أو الهاتف على:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-863-1019, 800-537-7697 (رقم هاتف الصم والبكم)

تتوافر نماذج الشكاوى على الرابط http://www.hhs.gov/ocr/office/file/index.html.

Chinese

TML Health 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人. TML Health 不因種、膚色、民族血統、年齡、殘障或性別而排斥任何人或以不同的方式對待他們。

TML Health:

- 向殘障人士免費提供各種援助和服務，以幫助他們與我們進行有效溝通，如：
    - 合格的手語翻譯員
- 以其他格式提供的書面資訊（大號字體、音訊、無障礙電子格式、其他格式）
- 向母語非英語的人員免費提供各種語言服務，如：
    - 合格的翻譯員
    - 以其他語言書寫的資訊

如果您需要此類服務，請聯絡 Civil Rights Coordinator

如果您認為 TML Health 未能提供此類服務或者因種族、膚色、民族血統、年齡、殘障或性別而透過其他方式歧視您，您可以向 Civil Rights Coordinator 提交投訴，郵寄地址為 PO Box 149190, Austin, TX 78754-9190, 電話號碼為 1-800-282-5385 TTY（聽障專線）號碼為 711, 傳真為 512-719-6539, 電子信箱為 CRCoordinator@tmlhb.org. 您可以親自提交投訴，或者以郵寄、傳真或電郵的方式提交投訴。如果您在提交投訴方面需要幫助，Civil Rights Coordinator 可以幫助您.

您還可以向 U.S. Department of Health and Human Services（美國衛生及公共服務部）的 Office for Civil Rights（民權辦公室）提交民權投訴，透過 Office for Civil Rights Complaint Portal 以電子方式投訴：https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. 或者透過郵寄或電話的方式投訴：

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C.20201

1-800-368-1019, 800-537-7697 (TDD)（聾人用電信設備）

登入 http://www.hhs.gov/ocr/office/file/index.html 可獲得投訴表格.

French

TML Health respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap. TML Health n'exclut et ne traite aucune personne différemment en raison de sa race, sa couleur de peau, son origine nationale, son âge, son sexe ou son handicap.

TML Health :

- Fournit gratuitement des aides et services aux personnes handicapées afin de permettre une communication efficace avec nous, par exemple :
    - Interprètes qualifiés en langue des signes
- Informations écrites dans d'autres formats (gros caractères, audio, formats électroniques accessibles, autres formats)
- Fournit gratuitement des services linguistiques aux personnes dont la langue principale n'est pas l'anglais, par exemple:
    - Interprètes qualifiés
    - Informations écrites dans d'autres langues

Si vous avez besoin de ces services, contactez Civil Rights Coordinator

Si vous pensez que TML Health n'a pas fourni ces services ou a fait preuve d'une autre forme de discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou le handicap, vous pouvez déposer une réclamation auprès de : Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. Vous pouvez déposer une réclamation en personne ou par courrier, télécopie ou e-mail. Si vous avez besoin d'aide pour déposer une réclamation, Civil Rights Coordinator se tient à votre disposition pour vous y aider.

Vous pouvez également déposer une réclamation concernant vos droits civiques auprès de l'U.S. Department of Health and Human Services (Département de la Santé et des Services Sociaux des États-Unis), Office for Civil Rights (Bureau des Droits Civiques), par voie électronique via l'Office for Civil Rights Complaint Portal, disponible à l'adresse https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, par courrier ou par téléphone à :

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Des formulaires de réclamation sont disponibles à l'adresse http://www.hhs.gov/ocr/office/file/index.html.

German

TML Health erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab. TML Health lehnt den Ausschluss oder die unterschiedliche Behandlung von Menschen aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

TML Health:

- Bietet kostenlose Hilfe und Dienstleistungen für Menschen mit Behinderung zur effektiven Kommunikation, wie z. B.:
    - Qualifizierte Gebärdensprachen-Dolmetscher
- Schriftliche Informationen in anderen Formaten (große Ausdrucke, Audio, zugängliche elektronische Formate, sonstige Formate)
- Bietet kostenlose Sprachdienste für Menschen, deren Hauptsprache nicht Englisch ist, wie z. B.:
    - Qualifizierte Dolmetscher
    - Schriftliche Informationen in anderen Sprachen

Sollten Sie diese Dienstleistungen benötigen, so wenden Sie sich an Civil Rights Coordinator

Sollten Sie der Ansicht sein, dass TML Health es versäumte, diese Dienstleistungen anzubieten, oder auf sonstige Weise aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht diskriminierte, so können Sie eine Beschwerde einreichen bei: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. Sie können eine Beschwerde persönlich oder per Post, Fax oder E-Mail einreichen. Sollten Sie Hilfe beim Einreichen einer Beschwerde benötigen, so steht Ihnen Civil Rights Coordinator gerne zur Verfügung.

Sie können ebenfalls eine Menschenrechtsbeschwerde einreichen bei: Department of Health and Human Services (U.S.-Gesundheitsministerium), Office for Civil Rights (Amt für Bürgerrechte), elektronisch über das Office for Civil Rights Complaint Portal, zugänglich über https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, oder per Post oder telefonisch an:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Beschwerdeformulare sind verfügbar unter http://www.hhs.gov/ocr/office/file/index.html.

Gujarati

TML Health સમવાયી નાગરકિ અધકિાર કાયદા સાથે સુસંગત છે અને જાત,િ રંગ, રાષ્ટ્રીય મૂળ, ઉમર,અશક્તતા અથવા લગિના આધારે ભેદભાવ રાખવામાં આવતો નથી. TML Health જાત,િ રંગ, રાષ્ટ્રીય મૂળ, ઉમર, અશક્તતા, અથવા લૈંગકિ કારણે લોકો બાકાત નથી અથવા તેમની સાથે અલગ વર્તન કરવામાં આવતું નથી.

TML Health:

- અમારી સાથે અસરકારક રીતે સંદેશાવ્યવહાર કરવામાં અક્ષમ જેવા કે અશક્ત લોકો માટે નીચે પ્રમાણેની મફત સહાય અને સેવાઓ પૂરી પાડવામાં આવે છે:
    - લાયકાત ધરાવતા સાંકેતકિ ભાષાના દુભાષયિા
    - અન્ય ફોર્મેટમાં લખાયેલ માહતિી (મોટી પ્રન્ટિ, ઓડયિો, સુલભ ઇલેક્ટ્રોનકિ ફોર્મેટ, અન્ય ફોર્મેટ)
- જેની પ્રાથમકિ ભાષા અંગ્રેજી ન હોય તેવા લોકોને નીચે પ્રમાણેની મફત ભાષા સેવાઓ પૂરી પાડવામાં આવે છે:
    - લાયકાત ધરાવતા દુભાષયિા
    - અન્ય ભાષાઓમાં લખવામાં આવેલી માહતિી

તમારે આ સેવાઓની જરૂર હોય તો, સંપર્ક કરો Civil Rights Coordinator

જો તમે માનતા હો કે આ સેવાઓ પૂરી પાડવા માટે TML Health નષ્ફિળ ગયા છે અથવા જાત,િ રંગ, રાષ્ટ્રીય મૂળ, ઉમર, અશક્તતા અથવા લગિના આધારે અથવા અન્ય પ્રકારે ભેદભાવ રાખે છે, તો તમે Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org સમક્ષ ફરયિાદ દાખલ કરી શકો છો. તમે ફરયિાદ રૂબરૂમાં અથવા મેઇલ, ફેક્સ, અથવા ઇમેઇલ દ્વારા દાખલ કરી શકો છો. તમને ફરયિાદ દાખલ કરવામાં મદદ જોઈતી હોય તો Civil Rights Coordinator તમને મદદ કરવા માટે ઉપલબ્ધ છે.

તમેthe U.S. Department of Health and Human Services (ધી યુ. એસ. ડીપાર્ટમેંટ ઓફ હેલ્થ એન્ડ હ્યુમન સર્વીસસિ), Office for Civil Rights (ઓફીસ ફોર સવિલિ રાઇટસ]ને પણ) https://ocrportal.hhs.gov/ocr/portal/lobby.jsf પર ઉપલબ્ધ Office for Civil Rights ComplaintPortal, મારફતે વજિાણુ રીતે અથવા નીચેના સરનામે મેઇલ કે ફોન કરી ફરયિાદ નોંધાવી શકો છો

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-868-1019, 800-537-7697 (TDD)

ફરયિાદનું ફોર્મ અહી ઉપલબ્ધ છે http://www.hhs.gov/ocr/office/file/index.html.

Hindi

TML Health लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है। TML Health जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर लोगों को बाहर या उनके साथ अलग तरह का बर्ताव नहीं करता है।

TML Health:

- विकलांग लोगों को हमारे साथ प्रभावशाली ढंग से संवाद करने के लिए निःशुल्क सहायता और सेवाएं प्रदान करता है, जैसे:
    - योग्यताप्राप्त सांकेतिक भाषा दुभाषिया
- अन्य फॉर्मेट (बड़े प्रिंट, ऑडियो, सुलभ इलेक्ट्रॉनिक फॉर्मेट, अन्य फॉर्मेट) में लिखित जानकारी
- जिन लोगों की प्राथमिक भाषा अंग्रेज़ी नहीं है उन लोगों को निःशुल्क भाषा सेवाएं प्रदान करता है, जैसे:
    - योग्यताप्राप्त दुभाषिया
    - अन्य भाषाओं में लिखित जानकारी

यदि आपको इन सेवाओं की आवश्यकता है तो Civil Rights Coordinator से संपर्क करें

यदि आपको विश्वास है कि TML Health ये सेवाएं प्रदान करने में विफल रहा है या जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर किसी तरह से कोई भेदभाव किया है तो आप निम्नलिखित के पास शिकायत दर्ज करा सकते हैं: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. आप स्वयं जाकर या डाक, फैक्स, या ईमेल द्वारा भी शिकायत दर्ज करा सकते हैं। यदि आपको शिकायत दर्ज कराने में सहायता की आवश्यकता है तो Civil Rights Coordinator आपकी सहायता के लिए उपलब्ध है।

आप https://ocrportal.hhs.gov/ocr/portal/lobby.jsf पर उपलब्ध, Office for Civil Rights Complaint Portal के माध्यम से इलेक्ट्रॉनिक तरीके से, या डाक या फोन द्वारा भी U.S. Department of Health and Human Services (यू.एस. डिपार्टमेंट ऑफ़ हेल्थ एण्ड ह्यूमन सर्विसेज़), Office for Civil Rights (ऑफिस फॉर सिविल राइट्स) के पास भी एक नागरिक अधिकार शिकायत दर्ज करा सकते हैं:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-868-1019, 800-537-7697 (TDD)

शिकायत फॉर्म http://www.hhs.gov/ocr/office/file/index.html पर उपलब्ध हैं।

Japanese

TML Health は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害、または性別に基づく差別をいたしません. TML Health は人種、肌の色、出身国、年齢、障害、または性別を理由として人を排除したり、異なる扱いをいたしませ.

TML Health は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害、または性別に基づく差別をいたしません。TML Health は人種、肌の色、出身国、年齢、障害、または性別を理由として人を排除したり、異なる扱いをいたしません。

TML Health:

- 効果的にコミュニケーションを図るため、障害のある人に以下の支援やサポートを無料で提供いたします。
    - 資格ある手話通訳者
    - その他形式の文字情報（大きな活字、音声信号、手軽な電子形式、その他）
- 英語を母語としない人へ以下の言語サービスを無料で提供いたします。
    - 資格ある通訳者
    - 英語以外の言語で書かれた情報

これらのサービスを必要とされる場合は、Civil Rights Coordinatorまでご連絡ください。

TML Health がこれらのサービスの提供を怠ったり、人種、肌の色、出身国、年齢、障害、または性別に基づいた何らかの方法で差別したと思われる場合、こちらまで苦情を申し立てることができます：Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. 苦情の申し立ては、直接、または郵便、ファックス、メールで行うことができます。苦情を申し立てるにあたり援助が必要な場合は、Civil Rights Coordinator がお手伝いいたします.

また、公民権に関する苦情は、U.S. Department of Health and Human Services（保健社会福祉省）の Office for Civil Rights（公民権局）へ、Office for Civil Rights Complaint Portal https://ocrportal.hhs.gov/ocr/portal/lobby.jsf から電子申請するか、以下へ郵便または電話で申し立てることもできます:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C.20201

1-800-368-1019, 800-537-7697 (TDD)

苦情申立書は http://www.hhs.gov/ocr/office/file/index.html よりダウンロードいただけます.

Korean

TML Health 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다. TML Health 은(는) 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 누군가를 배제하거나 다른 방식으로 대우하지 않습니다.

TML Health:

- 장애인들이 저희와 효과적으로 의사소통할 수 있도록 다음과 같은 무료 지원과 서비스를 제공합니다.
    - 자격있는 수화 통역자
    - 다른 형식의 서면 정보(큰 활자, 음성, 사용 가능한 전자 형식, 기타 형식)
- 주로 사용하는 언어가 영어가 아닌 이들에게는 다음과 같은 무료 언어 서비스를 제공합니다.
    - 자격있는 통역자
    - 다른 언어로 작성된 서면 정보

이러한 서비스가 필요하시면 Civil Rights Coordinator 에 연락하십시오.

TML Health 이(가) 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 이러한 서비스를 제공하지 않거나 다른 방식으로 차별했다고 생각하시는 경우 Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org (으)로 연락하여 불만을 제기하실 수 있습니다. 직접 방문하거나 우편, 팩스 또는 이메일로 불만을 제기하실 수 있습니다. 불만 제기와 관련하여 도움이 필요하시면, Civil Rights Coordinator (으)로부터 지원을 받으실 수 있습니다.

또한 공민권 민원을 미국 Department of Health and Human Services (보건복지부), Office for Civil Rights (시민권 사무국)에 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf 에 있는 시민권 사무국 민원 포털을 통해 전자 방식으로 제출하거나 우편이나 전화로 제출할 수 있습니다. 주소 및 연락처는 다음과 같습니다.

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민원 양식은 http://www.hhs.gov/ocr/office/file/index.html 에 있습니다.

Lao

TML Health ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຣັຖບານກາງທີ່ບັງຄັບໃຊ້ ແລະ ບໍ່ຈຳແນກບຸກຄົນໂດຍອີງໃສ່ພື້ນຖານດ້ານ ເຊື້ອຊາດ, ສີຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ. TML Health ບໍ່ຈຳແນກບຸກຄົນ ຫຼື ປະຕິບັດຕໍ່ພວກເຂົາໂດຍແຕກຕ່າງດ້ວຍເຫດຜົນດ້ານ ເຊື້ອຊາດ, ສີຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.

TML Health:

- ໃຫ້ການຊ່ວຍເຫຼືອ ແລະການບໍລິການ ໂດຍບໍ່ເສັຽຄ່າ ແກ່ບຸກຄົນທີ່ພິການ ເພື່ອໃຫ້ສາມາດສື່ສານກັບພວກເຮົາໄດ້ຢ່າງມີປະສິດທິພາບ, ເຊັ່ນ:
  - ນາຍພາສາໃບ້ທີ່ມີຄຸນສົມບັດເໝາະສົມ
  - ຂໍ້ມູນທີ່ເປັນລາຍລັກອັກສອນໃນຮູບແບບອື່ນໆ (ເຊັ່ນ ຕົວພິມໃຫຍ່, ເຫັບ ບັນທຶກ, ຮູບແບບ ອີເລັກໂຕຣນິກທີ່ເຂົ້າເຖິງໄດ້, ຮູບແບບອື່ນໆ)
- ໃຫ້ບໍລິການດ້ານພາສາໂດຍບໍ່ເສັຽຄ່າ ແກ່ບຸກຄົນທີ່ພາສາຫຼັກຂອງເຂົາເຈົ້າບໍ່ແມ່ນພາສາອັງກິດ, ເຊັ່ນ:
  - ນາຍພາສາທີ່ມີຄຸນສົມບັດເໝາະສົມ
  - ຂໍ້ມູນທີ່ຂຽນໃນພາສາອື່ນ

ຖ້າວ່າທ່ານຕ້ອງການບໍລິການເຫຼົ່ານີ້, ຈົ່ງຕິດຕໍ່ Civil Rights Coordinator

ຖ້າວ່າທ່ານເຊື່ອວ່າ TML Health ບໍ່ໃຫ້ການບໍລິການເຫຼົ່ານີ້ ຫຼື ຈຳແນກໃນທາງອື່ນ ໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ສີຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ, ທ່ານສາມາດຍື່ນເລື້ອງຮ້ອງທຸກ ກັບ: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. ທ່ານສາມາດຍື່ນເລື້ອງຮ້ອງທຸກດ້ວຍຕົນເອງ ຫຼື ໂດຍທາງຈົດໝາຍ, ແຟກຊ໌, ຫຼື ອີເມວ. ຖ້າວ່າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການປະກອບຄຳຮ້ອງທຸກ, Civil Rights Coordinator ແມ່ນພ້ອມຊ່ວຍເຫຼືອທ່ານ.

ນອກຈາກນີ້ ທ່ານຍັງສາມາດຮ້ອງທຸກດ້ານສິດທິພົນລະເມືອງໄດ້ກັບທາງ U.S. Department of Health and Human Services (ກະຊວງປະຊາສົງເຄາະແລະສຸຂະພາບຂອງສະຫະຣັຖ), Office for Civil Rights (ຫ້ອງການສິດທິພົນລະເມືອງ), ໂດຍທາງອີເລັກໂຕຣນິກ ຜ່ານ Office for Civil Rights Complaint Portal, ຊຶ່ງມີໃຫ້ທີ່ເວັບໄຊ https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, ຫຼື ໂດຍທາງໄປສະນີ ຫຼື ທາງໂທຣະສັບ ທີ່:

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Washington, D.C. 20201

1-800-868-1019, 800-537-7697 (TDD)

ຟອມຄຳຮ້ອງທຸກ ມີໃຫ້ທີ່ເວັບໄຊ http://www.hhs.gov/ocr/office/file/index.html.

Persian Farsi

TML Health از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

TML Health بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد ایشان را از خدمات محروم نمی کند و با آنها برخورد متفاوتی ندارد.

:TML Health

- برای افرادی که ناتوانی دارند، برای برقرار کردن ارتباط موثر، کمک هایی بطور رایگان فراهم می کند، مانند:
  - مترجمین واجد شرایط زبان اشاره
  - اطلاعات نوشتاری به فرمت های دیگر (چاپ با حروف درشت، صوتی، فرمت های الکترونیک قابل دسترسی ساده، و فرمت های دیگر)
- برای افرادی که زبان اولیه شان انگلیسی نیست خدمات زبانی رایگان ارایه می کند، مانند:
  - مترجمین شفاهی واجد شرایط
  - اطلاعات نوشتاری به زبانهای دیگر

اگر به چنین خدماتی نیاز دارید، با Civil Rights Coordinator تماس بگیرید

اگر معتقدید که TML Health چنین خدماتی را به شما ارایه نداده و یا اینکه به شکلی دیگر به دلیل نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت درمورد شما تبعیض قایل شده می توانید شکواییه ای به این آدرس ثبت کنید:

Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org.

می توانید با مراجعه شخصی، نامه پستی، فکس یا ایمیل شکواییه خود را ثبت نمایید. اگر برای ثبت شکواییه خود به کمک نیاز دارید، Civil Rights Coordinator می تواند به شما کمک کند.

می توانید از طریق U.S. Department of Health and Human Services (وزارت بهداشت و خدمات انسانی آمریکا)، Office for Civil Rights (اداره حمایت از حقوق مدنی)، شکواییه خود را ثبت نمایید. دسترسی الکترونیکی به این اداره از طریق Office for Civil Rights Complaint Portal به آدرس https://ocrportal.hhs.gov/ocr/portal/lobby.jsf یا تماس از طریق ایمیل یا تلفن با آدرس زیر میسر است:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

فرم های مربوطه برای شکواییه در آدرس اینترنتی http://www.hhs.gov/ocr/office/file/index.html موجود است.

Russian

TML Health соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола. TML Health не исключает людей и не относится к ним по-разному из-за расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

TML Health:

- Для эффективного взаимодействия предоставляет безвозмездную помощь и оказывает услуги людям с ограниченными возможностями, а именно:
    - услуги квалифицированных сурдопереводчиков;
- письменную информацию в других форматах (крупный шрифт, аудио формат, доступные электронные форматы, прочие форматы).
- Предоставляет бесплатные услуги перевода людям, для которых английский не является основным языком, а именно:
    - услуги квалифицированных переводчиков;
    - письменную информацию на других языках.

Если вы нуждаетесь в таких услугах, обратитесь к Civil Rights Coordinator

Если вы считаете, что в TML Health вам не предоставили указанных услуг или иным образом дискриминировали вас по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола, вы можете подать жалобу: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. Вы можете подать жалобу лично или отправить по почте, факсу или электронной почте. Если вам нужна помощь в подаче жалобы, вам поможет Civil Rights Coordinator.

Вы также можете подать жалобу о нарушении гражданских прав в U.S. Department of Health and Human Services (Министерство здравоохранения и социальных служб США), Office for Civil Rights (Управление по гражданским правам), в электронном виде через Office for Civil Rights Complaint Portal, доступный по ссылке: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, по почте или по телефону:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201 (США)

1-800-368-1019, 800-537-7697 (TDD)

Бланки жалобы доступны по адресу: http://www.hhs.gov/ocr/office/file/index.html.

Spanish

TML Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. TML Health no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

TML Health:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
    - Intérpretes de lenguaje de señas capacitados.
    - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
    - Intérpretes capacitados.
    - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Civil Rights Coordinator.

Si considera que TML Health no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Civil Rights Coordinator está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

Tagalog

Sumusunod ang TML Health sa mga naaangkop na Pampederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian. Ang TML Health ay hindi nagtatangi ng mga tao o hindi nagpapakita ng ibang pakikitungo dahil sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Ang TML Health ay:

- Nagbibigay ng mga libreng tulong at serbisyo sa mga taong may kapansanan upang mahusay silang makipag-ugnayan sa amin, gaya ng:
    - Mga kwalipikadong interpreter ng sign language
    - Nakasulat na impormasyon sa iba pang mga format (malaking print, audio, mga naa-access na electronic na format, iba pang mga format)
- Nagbibigay ng mga libreng serbisyo sa wika sa mga taong hindi Ingles ang pangunahing wika, gaya ng:
    - Mga kwalipikadong interpreter
    - Impormasyong nakasulat sa iba pang mga wika

Kung kailangan mo ang mga serbisyong ito, makipag-ugnayan kay Civil Rights Coordinator

Kung naniniwala kang hindi naibigay ng TML Health ang mga serbisyong ito o nandiskrimina ito sa ibang paraan batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian, maaari kang maghain ng karaingan sa: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. Maaari kang maghain ng karaingan nang personal o sa pamamagitan ng koreo, fax o email. Kung kailangan mo ng tulong sa paghahain ng karaingan, narito si Civil Rights Coordinator upang tulungan ka.

Maaari ka ring maghain ng reklamo sa mga karapatang sibil sa U.S. Department of Health and Human Services (Kagawaran ng Mga Serbisyong Pangkalusugan at Pantao ng U.S.), Office for Civil Rights (Tanggapan para sa Mga Karapatang Sibil), sa electronic na paraan sa Office for Civil Rights Complaint Portal, na makikita sa https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o sa pamamagitan ng koreo o telepono sa:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Ang mga form ng reklamo ay makukuha sa http://www.hhs.gov/ocr/office/file/index.html.

Urdu

TML Health قابلِ اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتاTML Healthنسل، رنگ، قومیت، عمر، معذوری یا جنس پر لوگوں کی ممانعت نہیں کرتا اور نہ ہی ان کے باعث ان کے ساتھ مختلف برتاؤ کرتا ہے۔

:TML Health

- معذور افراد کے ہمارے ساتھ موّثر ابلاغ کے لیے مفت میں مدد اور خدمات فراہم کرتا ہے، مثلاً:
  - اہل اشاروں کی زبان کے ترجمان
  - دیگر صورتوں میں تحریری معلومات (بڑے پرنٹس، صوتی، قابلِ رسائی برقی تراتیب، دیگر تراتیب)
- وہ لوگ جن کی اولین زبان انگریزی نہیں ہے ان کو مفت زبان کی خدمات فراہم کرتا ہے، مثلاً
  - اہل ترجمان
  - دیگر زبانوں میں تحریر کردہ معلومات

اگر آپ کو ان خدمات کی ضرورت ہو تورابطہ کریں Civil Rights Coordinator

اگر آپ سمجھے/سمجھتی ہیں کہ TML Health ان خدمات کی فراہمی میں ناکام رہا ہے یا وہ نسل، رنگ، قومیت، عمر، معذوری یا جنس یا کسی دوسری صورت میں امتیاز کرتا ہے تو آپ ان رابطوں پر شکایت درج کرواسکتے ہیں:-Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org- آپ اپنی شکایت رُوبرُو یا ڈاک، فیکس یا ای میل کے ذریعے کرواسکتے ہیں۔ اگر آپ کو شکایت کروانے میں مدد درکار ہو تو Civil Rights Coordinator آپ کی مدد کے لیے دستیاب ہے۔

آپ شہری حقوق کی شکایات U.S. Department of Health and Human Services (ریاستہائے متحدہ امریکہ کے محکمہ صحت اور انسانی حقوق کی خدمات)، Office for Civil Rights (شہری حقوق کے دفتر)، https://ocrportal.hhs.gov/ocr/portal/lobby.jsf پر دستیاب کے Office for Civil Rights Complaint Portal کے ذریعے برقی طور پر یا ای میل یا ٹیلی فون پر بھی درج کروا سکتے/سکتی ہیں :

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-868-1019, 800-537-7697 (TDD)

شکایت کے فارم یہاں پر دستیاب ہیں http://www.hhs.gov/ocr/office/file/index.html-

Vietnamese

TML Health tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính. TML Health không loại trừ mọi người hoặc đối xử với họ khác biệt vì chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

TML Health:

- Cung cấp dịch vụ hỗ trợ miễn phí cho những người khuyết tật để giao tiếp với chúng tôi có hiệu quả, như:
    - Thông dịch viên ngôn ngữ ký hiệu đủ năng lực
    - Thông tin bằng văn bản ở các định dạng khác (chữ in lớn, âm thanh, định dạng điện tử có thể tiếp cận, các định dạng khác)
- Cung cấp miễn phí các dịch vụ ngôn ngữ cho những người có ngôn ngữ chính không phải là tiếng Anh, như:
    - Thông dịch viên đủ năng lực
    - Thông tin được trình bày bằng ngôn ngữ khác

Nếu bạn cần những dịch vụ này, hãy liên hệ Civil Rights Coordinator

Nếu bạn tin rằng TML Health không cung cấp những dịch vụ này hoặc phân biệt đối xử theo cách khác dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính, bạn có thể nộp đơn khiếu nại với: Civil Rights Coordinator, PO Box 149190, Austin, TX 78754-9190, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org. Bạn có thể trực tiếp nộp đơn khiếu nại hoặc gửi qua đường bưu điện, chuyển fax, hoặc email. Nếu bạn cần trợ giúp nộp đơn khiếu nại, Civil Rights Coordinator sẵn sàng giúp bạn.

Bạn cũng có thể nộp đơn khiếu nại về dân quyền lên U.S. Department of Health and Human Services (Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ), Office for Civil Rights (Văn Phòng Dân Quyền) bằng hình thức điện tử qua Office for Civil Rights Complaint Portal, có trên trang https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, hoặc qua đường bưu điện hoặc bằng điện thoại tại:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

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Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Các mẫu khiếu nại có trên trang http://www.hhs.gov/ocr/office/file/index.html.

Member Rights and Responsibilities Statement

Rights	Responsibilites
Membership	
You have the right to:	**You have the responsibility to:**
Receive information about the organization, its services, its practitioners and providers and member's rights and responsibilities.	Provide, to the extent possible, information that your health benefit plan and practitioner/provider need, in order to provide care.
Make recommendations regarding the organization's member rights and responsibilities policy.	

Rights	Responsibilites
Communication	
You have the right to:	**You have the responsibility to:**
Participate with practitioners in making decisions about your healthcare.	Follow the plans and instruction for care you have agreed to with your practitioner.
Be treated with respect and recognition of your dignity and your right to privacy.	Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.
A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.	
Voice complaints or appeals about the organization or the care it provides.	

"From day one, our focus has never been on profit, but the service and lives of our members."

Jay Stokes, *TML Health Board Member*

TML Health Benefits Pool

1821 Rutherford Lane, Suite 300
Austin, TX 78754-5151
(800) 282-5385

For more information, visit us at
tmlhealthbenefits.org

Follow us: **@TMLHealth**