



# PPO Select<sup>®</sup> Choice

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

## REQUIRED OUTLINE OF COVERAGE

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

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

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

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

**III. Benefits.** We have a network of Providers to serve Participants throughout Texas called the Network. When You use these Providers, You receive Network Benefits. You will receive a Provider Directory listing these Providers when You enroll and at least annually thereafter.

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

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

- A. **Benefit Period** – Your Benefit Period is a Calendar Year (begins January 1 and ends December 31).
- B. **Deductible** – The Calendar Year Deductible will be subtracted once during each Calendar Year from each Participant's total Eligible Expenses. The family Deductible is three times the individual Deductible amount. No Participant will be required to satisfy more than the individual Deductible amount toward the family Deductible amount. The amount of Your Deductibles will be as selected below:

Options	Network Deductibles		Out-of-Network Deductibles	
	Individual	Family	Individual	Family
Plan I <input type="checkbox"/>	\$250	\$750	\$500	\$1,500
Plan II <input type="checkbox"/>	\$500	\$1,500	\$1,000	\$3,000
Plan III <input type="checkbox"/>	\$1,000	\$3,000	\$2,000	\$6,000

Plan IV	<input type="checkbox"/>	\$1,500	\$4,500	\$3,000	\$9,000
Plan V	<input type="checkbox"/>	\$2,500	\$7,500	\$5,000	\$15,000
Plan VI	<input type="checkbox"/>	\$3,500	\$10,500	\$7,000	\$21,000
Plan VII	<input type="checkbox"/>	\$5,000	\$15,000	\$10,000	\$30,000
Plan VIII	<input type="checkbox"/>	\$10,000	\$30,000	\$20,000	\$60,000

C. **Copayment Amount** – The Copayment Amount will be required for each Physician office visit.

Options	Network Copayment Amount	Out-of-Network Copayment Amount
<i>Applicable to all Plans</i> Physician office visits*	\$25	None

\*All other *Medical-Surgical Expense* (diagnostic lab and x-ray) will be subject to Deductible and Coinsurance Amounts.

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

When a Hospital Admission is preauthorized, a length-of-stay is assigned. This Policy is required to provide a minimum length of stay in a Hospital for the treatment of breast cancer as follows:

Treatment of Breast Cancer

- (1) 48 hours following a mastectomy, and
- (2) 24 hours following a lymph node dissection.

Failure to preauthorize will result in a \$250 penalty for Hospital Admissions. A penalty in the amount of 50% not to exceed \$500 will apply to *Extended Care Expense* or Home Infusion Therapy for failure to preauthorize.

E. **Eligible Expenses** – After the applicable Deductible(s), if any, are met, Your coverage pays 80% of the Allowable Amount for Eligible Expenses provided by a Network Provider and 70% of the Allowable Amount for Eligible Expenses rendered by an Out-of-Network Provider, subject to other provisions of the Policy. The remainder of these Eligible Expenses becomes “Coinsurance Amounts” and must be paid by You.

## IMPORTANT TO YOUR COVERAGE

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

<b>EXAMPLE ONLY</b>	<b>In-Network</b>	<b>Out-of-Network</b>
	80% of eligible charges \$250 Deductible	70% of eligible charges \$500 Deductible
Amount Billed	\$20,000	\$20,000
Allowable Amount	\$5,000	\$5,000
Deductible Amount	\$250	\$500
Plan's Coinsurance Amount	\$3,800	\$3,150
Your Coinsurance Amount	\$950	\$1,350
Non-Contracting Provider's additional charge to you	None	\$15,000 <sup>1</sup>
<b>YOUR TOTAL PAYMENT</b>	<b>\$1,200 to a Network Provider</b>	<b>\$16,850 to a Non-contracting Out-of-Network Provider</b>

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

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

### 1. *Inpatient Hospital Expense:*

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

### 2. *Medical-Surgical Expense:*

- Services of Physicians, Professional Other Providers, and certified registered nurse-anesthetists (CRNA).
- Physical Medicine Services (therapies).
- Diagnostic x-ray, laboratory procedures, and radiation therapy.
- Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Amino acid-based elemental formulas.
- Rental of durable medical equipment (DME) required for therapeutic use (does not include such items as air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment).
- Emergency Medical Transportation to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.

- Anesthetics and administration when performed by someone other than the operating Physician or Professional Other Provider.
  - Oxygen and its administration provided the oxygen is used.
  - Blood, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for the Participant.
  - Prosthetic Appliances, excluding all replacements of such devices other than those required by growth to maturity of the Participant.
  - Orthotic Devices that are consistent with the Medicare Benefits Policy Manual.
  - Orthopedic braces and crutches.
  - Home Infusion Therapy.
  - Services or supplies received during an outpatient visit to a Hospital.
  - Diabetic Equipment and Supplies as described in the Policy.
  - Outpatient Contraceptive Services and prescriptive contraceptive devices. However, coverage for prescription oral contraception medications is provided under the Pharmacy Benefits.
  - Telehealth services and telemedical medicine services.
3. **Childhood Immunizations** – Childhood immunizations are available for a Dependent child from birth through age 7 at 100% of the Allowable Amount for Network and Out-of-Network Benefits. The Deductible will not apply.
4. **Preventive Care** – Benefits will be provided for the following Covered Services:
- evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
  - immunizations for Participants 8 years of age and over recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
  - evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
  - with respect to women, such additional preventive care and screenings, not described in the first bullet item above, as provided for in comprehensive guidelines supported by the HRSA.

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

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

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

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

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

Network Benefits	Out-of-Network Benefits
100% of the Allowable Amount	70% of the Allowable Amount after Calendar Year Deductible

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

Network Benefits	Out-of-Network Benefits
100% of the Allowable Amount	70% of the Allowable Amount No Calendar Year Deductible

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

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

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

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

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

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after Calendar Year Deductible	70% of the Allowable Amount after Calendar Year Deductible
Benefits are limited to a \$200 maximum benefit amount every five (5) years per Participant.	

F. **Out-of-Pocket Limit** — When a Participant’s Coinsurance Amounts for a Calendar Year equal the amounts shown below, the benefit percentages change to 100% for the remainder of that Calendar Year. The family Out-of-Pocket Limit is two times the individual Out-of-Pocket Limit. No Participant will be allowed to satisfy more than the individual Coinsurance Amount toward the family Coinsurance Amount.

<b>Options</b>	<b>Network Out-of-Pocket Limit</b>	<b>Out-of-Network Out-of-Pocket Limit</b>
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000

G. **Emergency Care Benefits** — Benefits are available for Emergency Care as follows:

<b>Covered Service</b>	<b>Network Benefits</b>	<b>Out-of-Network Benefits</b>
<b>Accident &amp; Medical Emergency</b> <ul style="list-style-type: none"> <li>▪ Facility Charges</li> <li>▪ Physician Charges</li> </ul>	<p style="text-align: center;">80% of Allowable Amount after Calendar Year Deductible</p> <p style="text-align: center;">80% of Allowable Amount after Calendar Year Deductible</p>	
<b>Non-Emergency Situations</b> <ul style="list-style-type: none"> <li>▪ Facility Charges</li> <li>▪ Physician Charges</li> </ul>	<p style="text-align: center;">80% of Allowable Amount after Calendar Year Deductible</p> <p style="text-align: center;">80% of Allowable Amount after Calendar Year Deductible</p>	<p style="text-align: center;">70% of Allowable Amount after Calendar Year Deductible</p> <p style="text-align: center;">70% of Allowable Amount after Calendar Year Deductible</p>

H. **Pharmacy Benefits, including Mail Order Pharmacy**

**Deductible/Copayment Amounts** – The Deductible must be satisfied before any Covered Drug benefits are payable under the Policy. The prescription drug Copayment Amounts are based on whether Your prescription is filled at a retail Pharmacy or through the mail-order Pharmacy.

**Copayment Amounts**

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

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

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

**How Preferred Drug Pricing Difference Applies**

- If Your physician has marked the prescription order “Brand Necessary”, the pharmacist may only dispense the brand name drug and You pay the appropriate Copayment Amount.
- If Your physician has not stipulated Brand Necessary, the Generic Drug will be dispensed unless You choose to purchase the brand name drug instead of the Generic Drug and if the brand name drug dispensed:

- Is on the Preferred Brand Name Drug List, You will pay the Preferred Brand Name Drug Copayment Amount **plus** the difference between the Generic Drug and the Preferred Brand Name Drug, or
- Is a Non-Preferred Brand Name Drug, You pay **only** the Non-Preferred Brand Name Drug Copayment Amount.

PHARMACY BENEFITS		
Plan Features		
Deductible \$200		
	Participating Pharmacy Participant pays...	Non-Participating Pharmacy Participant pays...
Retail Pharmacy 30-Day Supply	\$10 Copayment Amount after Calendar Year Deductible - Generic Drug  \$30 Copayment Amount after Calendar Year Deductible – Preferred Brand Name Drug  \$45 Copayment Amount after Calendar Year Deductible – Non-Preferred Brand Name Drug	20%** – Generic Drug  20%** – Preferred Brand Name Drug  100% - Non-Preferred Brand Name Drug
Mail Service 90-Day Supply	\$20 Copayment Amount after Calendar Year Deductible - Generic Drug  \$60 Copayment Amount after Calendar Year Deductible – Preferred Brand Name Drug  \$90 Copayment Amount after Calendar Year Deductible – Non-Preferred Brand Name Drug	
Specialty Drugs 30-Day Supply	\$10 Copayment Amount after Calendar Year Deductible - Generic Drug  \$30 Copayment Amount after Calendar Year Deductible – Preferred Brand Name Drug  \$45 Copayment Amount after Calendar Year Deductible – Non-Preferred Brand Name Drug	100%

\*\* of the billed charge (but not more than 20% of the Average Wholesale Price, plus a dispensing fee), less the appropriate Pharmacy Deductible, Copayment Amount and any applicable pricing differences.

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

#### IV. Limitations and Exclusions

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

- **Preexisting Condition Limitation** –Benefits of the Policy are not available for Care rendered during the first 12 months for conditions existing within 12 before the Effective Date of coverage (this limitation does not apply to a Participant under 19 years of age). This exclusion does not apply to a Participant who was continuously covered for an aggregate period of 18 months under Creditable Coverage if the previous coverage was in effect up to a date not more than 63 days before the Effective Date of the Participant’s coverage under this Policy.

If a Participant does not have aggregate Creditable Coverage totaling 18 months, We will credit the time the Participant was previously covered under Creditable Coverage if the previous coverage was in effect at any time during the 18 months preceding (a) the first day coverage is effective under this Policy if there is not a waiting period; or (b) the day the applicant files a substantially complete application for coverage if there is a waiting period.

- Maternity Care.
- Services or supplies not Medically Necessary for the treatment of a sickness, injury, condition, disease, or bodily malfunction; any Experimental/Investigational services and supplies.
- Any charges more than the Allowable Amount as determined by Us.
- Any services or supplies for which benefits are, or upon proper claim would be, provided under Workers' Compensation Law.
- Any services or supplies covered in whole or in part by any laws of the United States (including Medicare), a foreign country, state or political subdivision, **except** for Medicaid.
- Charges for services and supplies provided which require Our approval when approval is not given.
- Services or supplies for which You are not required to make payment or for which You are not legally required to pay without this or any similar coverage, (**except** treatment of mental illness or mental retardation by a tax supported institution).
- Any services or supplies provided by a person who is related to You by blood or marriage.
- Treatment of injury or sickness because of war, acts of war, or while on active or reserve military duty.
- Any charges because of suicide or attempted suicide.
- Charges resulting from failure to keep a scheduled visit with a Physician or Professional Other Provider, for completion of any insurance forms, or for acquisition of medical records unless requested and received by Us.
- Room and board charges during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been done on an outpatient basis.
- Services or supplies provided during a Hospital Admission or an admission in a Facility Other Provider beginning before the patient’s Effective Date, or services or supplies provided after the termination of the Participant’s coverage, **except** as provided in the Policy.
- Dietary and nutritional services, **except** as may be provided in the Policy for (1) a nutritional assessment program provided in and by a Hospital and approved in advance by Us; (2) ***Treatment of Diabetes***; and (3) ***Certain Therapies for Children with Developmental Delay***.
- Custodial Care.
- Routine physical examinations, unless specifically stated in the Policy.
- Services or supplies (**except** Medically Necessary diagnostic and/or surgical procedures) for treatment of the jaw bone joints, muscles, or their related structures with appliances or splints, physical therapy, or alteration to eliminate pain or dysfunction.

- Services or supplies provided to correct congenital, developmental or acquired deformities of the jaw bone after a Participant's 19th birthday.
- Any items of *Medical-Surgical Expense* provided for dental care and treatments, dental surgery, or dental appliances, **except** (1) Oral Surgery as defined in the Policy, (2) congenital defects of a dependent child, or (3) services made necessary by Accidental Injury.
- Cosmetic, Reconstructive or Plastic Surgery unless caused by injury, congenital defects of a dependent child, reconstructive surgery following cancer surgery; reconstructive surgery following mastectomy; surgery and reconstruction of the other breast to achieve symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.
- Eyeglasses, contact lenses, hearing aids, or examinations for the prescription of them; or examinations for detecting visual sharpness or level of hearing, or refractive surgery.
- Mental and nervous disorders **except** Organic Brain Disease as defined in the Policy.
- Except as specifically provided for in the Policy, any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling; any services or supplies provided by a Licensed Clinical Social Worker, a Licensed Professional Counselor, or a Marriage and Family Therapist.
- Treatment of adolescent behavior disorders, including conduct disorders and oppositional disorders.
- Occupational therapy services that do not consist of traditional physical therapy modalities and is not part of a physical rehabilitation program.
- Travel, whether recommended by a Physician or Professional Other Provider, **except** Emergency Medical Transportation as provided in the Policy.
- Treatment of obesity or weight, including surgical procedures, even if other health conditions might be helped by the reduction. This exclusion does not apply to healthy diet counseling or obesity screening/counseling.
- Any services or supplies for inpatient allergy testing, or any testing or treatment for environmental sensitivity or clinical ecology, or any treatment not recognized as safe and effective.
- Any services or supplies provided with chelation therapy **except** treatment of acute metal poisoning.
- Any services or supplies for sterilization reversal (male or female), transsexual surgery, sexual dysfunction, in vitro fertilization services, or artificial insemination.
- Routine foot care as described in the Policy.
- Any Speech and Hearing Services **except** as provided in the Policy for (1) *Extended Care Expense*, (2) *Preventive Care*; (3) *Newborn Screening Tests for Hearing Impairment* and (4) *Certain Therapies for Children with Developmental Delay*.
- Any services or supplies for reduction mammoplasty.
- Services or supplies for acupuncture, videofluoroscopy, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
- Services or supplies for treatment of Chemical Dependency; services or supplies provided by a Licensed Chemical Dependency Counselor; or a Licensed Psychological Associate.
- Orthodontic or other dental appliances; splints or bandages provided by a Physician in a non-hospital setting or purchased "over-the-counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts, **except** for podiatric appliances when provided in conjunction with treatment of diabetes.

- Services or supplies provided for or in conjunction with conditions, which have been specifically excluded for a Participant.
- Any drugs and medicines, **except as may be** provided under the Pharmacy Benefits, that are: (1) dispensed by a Pharmacy and received by the Participant while covered under this Policy, (2) dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by the Participant for use on an outpatient basis, (3) over-the-counter drugs and medicines; or drugs for which no charge is made, (4) prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, (5) Retin-A or pharmacological similar topical drugs, or (6) smoking cessation prescription drug products requiring a Prescription Order.
- Any services or supplies not specifically defined as Eligible Expenses in the Policy.

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

- Drugs which do not by law require a Prescription Order from a Provider (except injectable insulin); and drugs, or covered devices for which no valid Prescription Order is obtained.
- Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraceptive devices is provided under the medical portion of the Policy.
- Administration or injection of any drugs.
- Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this item shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy..
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Coinsurance Amount or Copayment Amount provided under the Policy.
- Infertility medications and fertility medications; prescription contraceptive devices, non-prescription contraceptive materials (**except** prescription oral contraceptive medications which are Legend Drugs. However, coverage for prescription contraceptive devices is provided under the medical portion of the Policy.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA).

- Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting; drugs given through routes other than subcutaneously in the home setting. This exception does not apply to dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. This exception also does not apply to amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins, severe food protein-induced enterocolitis syndromes, eosinophilic disorders, as evidenced by the results of biopsy and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. A Prescription Order from your Health Care Practitioner is required.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs prescribed and dispensed for the treatment of mental or nervous disorders except Organic Brain Disease as defined in the Policy.
- Drugs, the use or intended use of, which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the Program, or for which benefits have been exhausted.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Any smoking cessation products requiring a Prescription Order.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by BCBSTX.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
- Compound Drugs as defined in the Policy.
- Some equivalent drugs are manufactured under multiple brand-names. In such cases, BCBSTX may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this Plan, the brand name drug purchases will not be covered under any benefit level.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Prescription drugs required for international travel or work.
- Nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant.
- Drugs which are repackaged by a company other than the original manufacturer.

## V. Renewability

- A. The coverage of any Participant under the Policy will end on the earliest of the following dates:

- On the last day of the period for which premiums have been paid, subject to the Grace Period;
  - At the death of a Participant;
  - On the last day of any Policy Month in which a Participant no longer resides, lives, or works in an area for which We are authorized to provide coverage, but only if coverage is not renewed or not continued uniformly without regard to any health status-related factor of the Participant;
  - On the last day of the Policy Month in which We receive a written request from You to cancel Your coverage or another Participant's coverage;
  - On the Policy Date for fraudulent or intentional misrepresentation of a material fact; or
  - On the last day of the Policy Month in which: (1) Your spouse ceases to be a dependent, or (2) Your children reach age 26, or (3) Your disabled children are no longer disabled or dependent on You for more than one-half of their support.
- B. We have the right to cancel this Policy after 90 days notice to You but only if all PPO-SELCHOICE-5 Policies are being canceled provided each Participant shall have the option to purchase on a guaranteed issue basis any other individual health insurance policy We offer at the time of discontinuance of this Policy.
- C. If We cancel this Policy as stated in Section B, above, a Participant does not elect to purchase another hospital, medical or surgical policy, and if he is totally disabled on the cancellation date as described in Section B, above, coverage continues and shall be limited to: (1) the duration of the Benefit Period; (2) payment of maximum Policy benefits; or (3) a period not less than 90 days.
- D. We may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if We:
- Notify the Texas Department of Insurance Commissioner not later than 180 days prior to the date coverage under the first individual hospital, medical or surgical health benefit plan terminates;
  - Notify each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and
  - Act uniformly without regard to any Health-Status Related Factor of covered individuals or Dependents of covered individuals who may become eligible for coverage.

## VI. Premiums

A. The initial premium rate for Your Plan selection under this Policy is:

- Preferred category is \$\_\_\_\_\_.
- Standard category is \$\_\_\_\_\_.

There is a one time, nonrefundable application of \$30.00. The application fee must be submitted with Your application.

Enclose the premium with your application. Once underwriting is completed and you are approved for coverage, if additional premium is required, you will receive a supplemental bill.

Premiums are payable monthly, bi-monthly or quarterly and are due on the first day of each Policy Month.

B. The premium rates for this Policy are based on the sex and age of the Subscriber, place of residence, certain health conditions or a combination of such health conditions, including whether or not an applicant is a smoker or user of tobacco products, and the number and classification of family members to be included on the Policy. Changes in these factors may result in a change in the premium.

1. If You and/or Your spouse reach an age that results in a new premium rate, the premium will automatically change to the rate applicable to the new age.
  2. The rates provided to You are for the residence shown in Your application. It may not apply to a different place of residence. Your premium rates are subject to automatic adjustment upon change of residence.
  3. We also have the right to increase premiums after 60 days notice to You.
  4. If both husband and wife are on the same membership, Your premium will be calculated based on the age of each adult.
- C. A Grace Period is provided for each premium payment. The Grace Period will be 10 days for monthly or 31 days for quarterly.