

**Blue Cross and Blue Shield of Texas**  
(herein called “We, Us, Our”)

**BlueEdge<sup>SM</sup> Individual HSA**  
**Preferred Provider Plan providing**  
**Comprehensive Major Medical Coverage**  
**REQUIRED OUTLINE OF COVERAGE**

**I. Read Your Contract Carefully.** This Outline of Coverage provides a very brief description of some important features of Your Contract. This is not the insurance contract and only the actual contract provisions will control. The contract 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 CONTRACT CAREFULLY!**

**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 contract.

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

**B. Calendar Year Deductibles** – Your Deductibles are based on Your plan selection and whether You choose “Individual Coverage” or “Family Coverage.” If “Individual Coverage” is elected, the individual Deductible amount must be satisfied before any benefits under the contract will be available, with the exception of the child immunization and the hearing screening benefits. If “Family Coverage” is elected, the family Deductible amount must be satisfied by the family before benefits under the contract will be available, with the exception of the child immunization and the hearing screening benefits. The Deductible shall apply to all combined Inpatient Hospital Expense, Medical-Surgical Expense, Outpatient Prescription Drug, and/or Extended Care Expense.

| Plan Option                        | Network    |          | Out-of-Network |          |
|------------------------------------|------------|----------|----------------|----------|
|                                    | Individual | Family   | Individual     | Family   |
| Plan I <input type="checkbox"/>    | \$1,150    | \$2,300  | \$2,300        | \$4,600  |
| Plan II <input type="checkbox"/>   | \$1,750    | \$3,500  | \$3,500        | \$7,000  |
| Plan III <input type="checkbox"/>  | \$2,500    | \$5,000  | \$5,000        | \$10,000 |
| Plan IV <input type="checkbox"/>   | \$1,150    | \$2,300  | \$2,300        | \$4,600  |
| Plan V <input type="checkbox"/>    | \$1,750    | \$3,500  | \$3,500        | \$7,000  |
| Plan VI <input type="checkbox"/>   | \$2,500    | \$5,000  | \$5,000        | \$10,000 |
| Plan VII <input type="checkbox"/>  | \$3,500    | \$7,000  | \$7,000        | \$14,000 |
| Plan VIII <input type="checkbox"/> | \$5,000    | \$10,000 | \$10,000       | \$20,000 |

**C. Out-of-Pocket Maximum** – Your Out-of-Pocket Maximum is based on Your plan selection and whether You choose “Individual Coverage” or “Family Coverage.” Your Out-of-Pocket Maximum includes the Deductible, Coinsurance and any applicable Outpatient Prescription Drug Copayment Amounts. When the applicable Out-of-Pocket Maximum is reached, the benefit percentages for Eligible Expenses shall increase to 100% for the remainder of that Calendar Year. The Out-of-Pocket Maximum does not include:

- Services, supplies, and charges limited or excluded by the contract; or

- Expenses not covered because a benefit maximum has been reached; or
- Charges in excess of the Allowable Amount; or
- Penalties for not preauthorizing *Inpatient Hospital Expense*, *Extended Care Expense* or Home Infusion Therapy.

| Plan Options       |                          | Network    |          | Out-of-Network |          |
|--------------------|--------------------------|------------|----------|----------------|----------|
|                    |                          | Individual | Family   | Individual     | Family   |
| Plans I through VI | <input type="checkbox"/> | \$3,000    | \$6,000  | \$6,000        | \$12,000 |
| Plan VII           | <input type="checkbox"/> | \$3,500    | \$7,000  | \$7,000        | \$14,000 |
| Plan VIII          | <input type="checkbox"/> | \$5,000    | \$10,000 | \$10,000       | \$20,000 |

- D. **Pre-authorization** – Pre-authorization 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 pre-authorized, a length-of-stay is assigned. This Contract provides a minimum length-of-stay in a Hospital for the treatment of breast cancer, (1) 48 hours following a mastectomy, and (2) 24 hours following a lymph node dissection.

Failure to pre-authorize 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. **Coinsurance** – Based on Your plan selection, after the applicable Deductible(s), if any, are met, Your coverage pays a percentage of the Allowable Amount for Eligible Expenses provided by a Network Provider and an Out-of-Network Provider, subject to other provisions of the contract. Any remaining unpaid Eligible Expenses, if any, become Coinsurance and is applied to the Out-of-Pocket Maximum and must be paid by You.

| Plan Option      |                          | Network                                                 | Out-of-Network                                          |
|------------------|--------------------------|---------------------------------------------------------|---------------------------------------------------------|
| Plans I, II, III | <input type="checkbox"/> | 90% of Allowable Amount after Calendar Year Deductible  | 70% of Allowable Amount after Calendar Year Deductible  |
| Plans IV, V, VI  | <input type="checkbox"/> | 75% of Allowable Amount after Calendar Year Deductible  | 60% of Allowable Amount after Calendar Year Deductible  |
| Plans VII, VIII  | <input type="checkbox"/> | 100% of Allowable Amount after Calendar Year Deductible | 100% of Allowable Amount after Calendar Year Deductible |

#### 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, meaning your total payment responsibility will be even greater.)

#### EXAMPLE ONLY

|                                                     | In-Network<br>90% of eligible charges<br>\$2,000 Deductible | Out-of-Network<br>70% of eligible charges<br>\$4,000 Deductible        |
|-----------------------------------------------------|-------------------------------------------------------------|------------------------------------------------------------------------|
| Eligible Expenses Billed                            | \$20,000                                                    | \$20,000                                                               |
| Allowable Amount                                    | \$5,000                                                     | \$5,000                                                                |
| Deductible Amount                                   | \$2,000                                                     | \$4,000                                                                |
| Plan's Coinsurance Amount                           | \$2,700                                                     | \$700                                                                  |
| Your Coinsurance Amount                             | \$300                                                       | \$300                                                                  |
| Non-Contracting Provider's additional charge to you | None                                                        | \$15,000 <sup>1</sup>                                                  |
| <b>YOUR TOTAL PAYMENT</b>                           | <b>\$2,300</b><br><b>to a Network Provider</b>              | <b>\$19,300</b><br><b>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 Contract.

#### F. Covered Services and Supplies

| Covered Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Network Benefits                                                                                                             | Out-of-Network Benefits                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Lifetime Maximum each Participant</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | \$5,000,000                                                                                                                  |                                                                                                                                                                       |
| <b>Inpatient Hospital Expenses</b><br>All usual Hospital services and supplies, including semiprivate room, intensive care and coronary care units.                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Deductible and Coinsurance                                                                                                   | Deductible and Coinsurance                                                                                                                                            |
| <b>Medical-Surgical Expenses</b><br>Services of Physicians or Professional Other Providers, a certified registered nurse-anesthetist (CRNA), diagnostic X-ray and lab, radiation therapy, dietary formulas necessary for the treatment of PKU or other heritable diseases, rental of durable medical equipment (DME), anesthetics, oxygen, blood, Prosthetic Appliances, orthopedic braces and crutches, Home Infusion Therapy services, treatment of diabetes, outpatient services supplies and outpatient contraceptive services and contraceptive devices, Telehealth Services and Telemedicine Services. | Deductible and Coinsurance                                                                                                   | Deductible and Coinsurance                                                                                                                                            |
| <b>Physical Medicine Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Deductible and Coinsurance                                                                                                   | Deductible and Coinsurance                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$1,000 Calendar Year benefit maximum each Participant                                                                       |                                                                                                                                                                       |
| <b>Ground and Air Ambulance Services</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Network Deductible and Coinsurance<br>\$1,500 Calendar Year Maximum each Participant                                         |                                                                                                                                                                       |
| <b>Organ and Tissue Transplants</b><br>(Liver, Heart, Heart/Lung [heart and one lung or heart and two lungs], Cornea, Lung.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Deductible and Coinsurance                                                                                                   | Deductible and Coinsurance                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$300,000 Lifetime Maximum each Participant, subject to policy Lifetime Maximum                                              |                                                                                                                                                                       |
| <b>Extended Care Services</b><br><ul style="list-style-type: none"> <li>Skilled Nursing Facility</li> <li>Home Health Care</li> <li>Hospice Care</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 100% of Allowable Amount after Calendar Year Deductible                                                                      | 70% of Allowable Amount after Calendar Year Deductible for Plans I, II, III, IV, V, VI<br>100% of Allowable Amount after Calendar Year Deductible for Plan, VII, VIII |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | \$5,000 Calendar Year benefit maximum<br>\$5,000 Calendar Year benefit maximum<br>\$10,000 Lifetime Maximum each Participant |                                                                                                                                                                       |
| <b>Routine Mammography Screening</b><br>(For female Participants 35 years of age or older, limited to one each Calendar Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Deductible and Coinsurance                                                                                                   | Deductible and Coinsurance                                                                                                                                            |
| <b>Non-Routine Diagnostic Mammography</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Deductible and Coinsurance                                                                                                   | Deductible and Coinsurance                                                                                                                                            |

| Covered Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Network Benefits                             | Out-of-Network Benefits    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------|
| <b>Breast Reconstruction</b><br>(Services or supplies necessary to rebuild the breast and achieve reasonable breast symmetry as a result of a mastectomy)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Deductible and Coinsurance                   | Deductible and Coinsurance |
| <b>Tests for Detection of Prostate Cancer</b> <ul style="list-style-type: none"> <li>▪ A physical examination for the detection of prostate cancer</li> <li>▪ A prostate-specific antigen test used for the detection of prostate cancer for each male Participant who is at least: <ul style="list-style-type: none"> <li>– 50 years of age and asymptomatic, or</li> <li>– 40 years of age with a family history of prostate cancer or another prostate cancer risk factor</li> </ul> </li> </ul>                                                                                                                                                                                            | Deductible and Coinsurance                   | Deductible and Coinsurance |
| <b>Tests for Detection of Colorectal Cancer</b> <ul style="list-style-type: none"> <li>▪ Fecal occult blood test performed annually and flexible sigmoidoscopy every five years; or</li> <li>▪ Colonoscopy every ten years</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Deductible and Coinsurance                   | Deductible and Coinsurance |
| <b>Preventive Care</b> (Routine physical examinations, well child care, hemoccult tests, immunizations 6 years & over, routine lab, x-ray, vision and hearing exams) <i>Routine mammograms, colorectal cancer screenings, prostate cancer screenings, and HPV/cervical cancer screenings are not provided under this benefit.</i>                                                                                                                                                                                                                                                                                                                                                              | Deductible and Coinsurance                   | Deductible and Coinsurance |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$300 Calendar Year maximum each Participant |                            |
| <b>Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer</b> <ul style="list-style-type: none"> <li>▪ A conventional pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of human Papillomavirus.</li> <li>▪ Such screening test must be performed in accordance with the guidelines adopted by: <ul style="list-style-type: none"> <li>(a) The American College of obstetricians and Gynecologists; or</li> <li>(b) Another similar national organization of medical professionals.</li> </ul> </li> </ul> | Deductible and Coinsurance                   | Deductible and Coinsurance |
| <b>Childhood Immunizations</b> (From birth to 6 <sup>th</sup> birthdate) <i>Does not include allergy injections.</i> Immunizations includes but are not limited to, diphtheria, hemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization required by law.                                                                                                                                                                                                                                                                                                                                                           | 100% of Allowable Amount<br>No Deductible    |                            |

| Covered Services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Network Benefits                                                         | Out-of-Network Benefits                                  |                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------|
| <b>Hearing Screening (when offered by Hospital during a birth admission)</b><br>Screening tests for dependent children from birth through the date the child is 30 days old, and necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Coinsurance<br>No Deductible                                             | Coinsurance<br>No Deductible                             |                                      |
| <b>Certain Therapies for Children with Developmental Delay</b> <i>(up to age 3 as defined in the individualized family service plan as issued by the Texas Interagency Council on Early Childhood Intervention. Once the child reaches the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under this Contract, will be available. All contractual provisions of this Contract will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.)</i> <ul style="list-style-type: none"><li>▪ Occupational therapy evaluations</li><li>▪ Physical therapy evaluations and services</li><li>▪ Speech therapy evaluations and services; and</li><li>▪ Dietary or nutritional evaluations</li></ul> | Deductible and Coinsurance                                               | Deductible and Coinsurance                               |                                      |
| <b>Emergency Care</b> <ul style="list-style-type: none"><li>▪ <b>Accident &amp; Medical Emergency within 48 hours</b><ul style="list-style-type: none"><li>– Facility Charges</li><li>– Physician Charges</li></ul></li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Network Deductible and Coinsurance<br>Network Deductible and Coinsurance |                                                          |                                      |
| <ul style="list-style-type: none"><li>▪ <b>Non-Emergency Situations</b><ul style="list-style-type: none"><li>– Facility Charges</li><li>– Physician Charges</li></ul></li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Deductible and Coinsurance<br>Deductible and Coinsurance                 | Deductible and Coinsurance<br>Deductible and Coinsurance |                                      |
| OUTPATIENT PRESCRIPTION DRUGS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                          |                                                          |                                      |
| Plan Features                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Copayment Amounts<br><i>(Applies to all plans)</i>                       |                                                          |                                      |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Generic                                                                  | Preferred Brand Name Drug                                | Non-Preferred Brand Name Drug        |
| <b>Network/Out-of-Network Benefits</b> <ul style="list-style-type: none"><li>▪ 30-day supply on each occasion dispensed</li><li>▪ 90-day supply requires <i>three separate</i> Copayment Amounts</li><li>▪ \$5,000 Calendar Year maximum</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Deductible and \$10 Copayment Amount                                     | Deductible and \$50 Copayment Amount                     | Deductible and \$65 Copayment Amount |

Once the Calendar Year Deductible is met, the Copayment Amounts will apply until the Out-of-Pocket Maximum has been reached.

The amount of Your payment also depends on where Your prescription is filled and whether a generic substituted drug, Preferred Brand Name Drug or Non-Preferred Brand Name Drug is dispensed.

- If Your Physician has marked the prescription order “Brand Necessary,” the pharmacist may only dispense the brand name drug and You pay the appropriate Deductible, if applicable, or 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 Deductible, if applicable, or Copayment Amount **plus** the difference between the Generic Drug and the Preferred Brand Name Drug, or
  - A Non-Preferred Brand Name Drug, You pay **only** the Non-Preferred Brand Name Drug Deductible, if applicable, or Copayment Amount.

#### IV. Limitations and Exclusions

***Benefits under the Medical portion of the contract are not available for:***

- **Pre-existing Condition Limitation** – Benefits of the contract are not available for care rendered during the first twelve months for conditions existing within twelve months before the Effective Date of coverage. 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 Contract, excluding any waiting periods.

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 contract 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 contract.
- Dietary and nutritional services, except as may be provided in the contract 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, diagnostic screening, or immunizations, **except** as provided in the contract (1) ***Mammography Screening***, (2) ***Preventive Care*** up to the Calendar Year benefit maximum, (3) ***Childhood Immunizations***, (4) ***Certain Tests for the Detection of Prostate Cancer***, (5) ***Newborn Screening Tests for Hearing Impairment***, (6) ***Certain Tests for the Detection of Colorectal Cancer***; (7) ***Certain Therapies for Children with Developmental Delay***, and (8) ***Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer***.

- 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 Contract, (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 contract.
- Except as specifically provided in the contract, 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 ambulance services as provided in the contract.
- Treatment of obesity or weight, including surgical procedures, even if other health conditions might be helped by the reduction.
- 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 contract.
- Any Speech and Hearing Services except as provided in the contract for (1) Extended Care Expense, (2) ***Preventive Care*** up to the Calendar Year maximum, (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 has been specifically excluded for a Participant.
- Any services or supplies not specifically defined as Eligible Expenses in the contract.

***The benefits provided under the Outpatient Prescription Drug Coverage 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 contract.
- 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 the Workers' Compensation Law.
- Covered Drugs, devices, or other Pharmacy 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.
- 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 Deductible and Copayment Amount provided under the contract.
- 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 contract.
- 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.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs, the use or intended use of, which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the contract, 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).
- 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.

- Allergy serum and allergy testing materials.
- Injectable drugs, except those self-administered subcutaneously.
- Compounded drugs that do not meet the definition of Compound Drugs as defined in the contract.

## V. Renewability

- A. The coverage of any Participant under the contract 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 Contract Month in which a Participant no longer resides, lives, or works in an area for which We are authorized to do business, but only if coverage is terminated uniformly without regard to any health status-related factor of the Participant.
  - On the last day of the Contract Month in which We receive a written request from You to cancel Your coverage or another Participant's coverage;
  - On the contract date for fraudulent or intentional misrepresentation of a material fact; or
  - On the last day of the Contract Month in which: (1) Your spouse ceases to be a dependent, or (2) Your children marry or reach age 25, 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 contract after 90 days notice to You but only if all PPO-BLUEEDGE-INDL-HSA plan contracts are being canceled provided each Participant shall have the option to purchase on a guaranteed issue basis any other individual health insurance contract We offer at the time of discontinuance of this contract.
- C. If We cancel this contract 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 contract 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 contract 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 1<sup>st</sup> day of each month.

- B. The premium rates for this contract 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 contract. 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 30 days notice to You. However, except for an increase resulting from a change to a new age bracket, residence relocation to a new geographical area in Texas, or a change in the type of contract (family, single, dependent coverage, etc.) no increase in the initial premium can be made for six months.
  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.