



# individual products

## Benefit Comparisons Between Series III Products

This information is intended as a brief summary of the basic elements of PPO Select Saver, PPO Select Choice, and Select Blue Advantage Series III Products. All benefit payments are subject to the plan provisions contained in the Master Contract.

Plan Design	PPO Select® Saver <sup>SM</sup> (In-Network)	PPO Select® Choice (In-Network)	Select Blue Advantage (In-Network)
<b>Deductible Ranges</b>	\$500 – \$10,000	\$250 – \$10,000	\$250 – \$10,000
<b>Office Visit Copays</b>	None – Deductible and Coinsurance	\$25 Consultation only	\$25 (includes same day lab / x-ray up to \$750 annual maximum per person)
<b>Emergency Room Copay</b>	None – Subject to Deductible and Coinsurance	None – Subject to Deductible and Coinsurance	\$100* (facility charges only)
<b>Out-of-Pocket Maximum**</b>	\$3,000 Individual / \$9,000 Family	\$3,000 Individual / \$6,000 Family	\$3,000 Individual / \$6,000 Family
<b>Coinsurance</b>	75% / 25% of allowable amount	80% / 20% of allowable amount	85% / 15% of allowable amount
<b>Prescription Drug Deductible</b>	\$200	\$200	None
<b>Prescription Drug Program Copays</b>	3 tier open formulary \$10 / \$40 / \$55	3 tier open formulary \$10 / \$30 / \$45	\$10 / \$30 / \$45
<b>Mail Order Prescriptions</b>	90 days at 2 times Copay	90 days at 2 times Copay	90 days at 2 times Copay
<b>Prescription Drug Calendar Year Maximum</b>	\$3,000 per Participant	\$3,000 per Participant	\$3,000 per Participant
<b>Adult Preventive Care</b>	75% allowable amount subject to deductible and coinsurance and \$300 calendar year maximum per participant	100% allowable amount subject to office visit copay and \$300 calendar year maximum per participant	100% allowable amount subject to office visit copay and \$300 calendar year maximum per participant
<b>Well Child Care</b> (through age 7)	Routine physical exams and developmental assessment, subject to deductible and coinsurance, and a \$300 calendar year maximum per participant. Immunizations through age 7, paid at 100%.	Routine physical exams and developmental assessment, subject to office visit copay, and a \$300 calendar year maximum per participant. Immunizations through age 7, paid at 100%.	Routine physical exams and developmental assessment, covered at 100% of allowable, subject to office visit copay and \$300 calendar year maximum per participant. Immunizations through age 7, paid at 100%.
<b>Lifetime Maximum</b>	\$5 Million per person	\$5 Million per person	\$5 Million per person
<b>Pre-existing Condition Clause</b>	12 months	12 months	18 months

\* Waived if admitted to hospital immediately following the visit.

\*\* Deductible not included.

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

**PPO SelectChoice**

**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. **Deductibles** – The Calendar Year Deductible will be subtracted once during each Calendar Year from each Participant’s total Eligible Expense. 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** (*Applicable to all Plans*) – A \$25 Copayment Amount is required for Physician office visits *only* when services are provided by a Network Physician at the time You receive the services. All other *Medical-Surgical Expense* (lab and x-ray) will be subject to Deductible and Coinsurance Amounts. No Copayment Amount is required when services are provided by an Out-of-Network Provider.

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 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 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) and Copayment Amounts, if any, are met, Your coverage pays 80% of the Allowable Amount for Eligible Expenses provided by a Network Provider and 75% of the Allowable Amount for Eligible Expenses rendered by an Out-of-Network Provider, subject to other provisions of the Contract. 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:**

**EXAMPLE ONLY**

	<b>In-Network</b> 80% of eligible charges \$250 Deductible	<b>Out-of-Network</b> 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	\$1,850
Non-Contracting Provider’s additional charge to you	None	\$15,000 <sup>1</sup>
<b>YOUR TOTAL PAYMENT</b>	<b>\$1,200</b> to a Network Provider	<b>\$17,350</b> to a Non-contracting Out-of-Network Provider

**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, for example, 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 will bill the patient for expenses over the Allowable Amount. Please refer to the section entitled *PARPLAN* in the Contract.**

1. ***Inpatient Hospital Expense:***

- a. 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.
- b. Intensive care and coronary care units.
- c. All other usual Hospital services.

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

- Services of Physicians, Professional Other Providers, and certified registered nurse-anesthetists (CRNA).
- Physical Medicine Services (therapies), up to a maximum benefit of \$1,000 for each Participant each Calendar Year.
- Diagnostic x-ray, laboratory procedures, and radiation therapy.
- Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- 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).
- Professional local ground or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition, up to a maximum benefit amount of \$1,500 per Participant each Calendar Year.
- 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.
- 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 Contract.
- Outpatient Contraceptive Services and prescriptive contraception devices. However, coverage for prescription oral contraceptive medications is provided under the Prescription Drug Program.
- Telehealth Services and Telemedicine Medical Services.

All benefit maximums apply to both Network Benefits and Out-of-Network Benefits.

3. **Childhood Immunizations** – Childhood immunizations are available for a Dependent child from birth to age 8 at 100% of the Allowable Amount for Network and Out-of-Network Benefits. The Deductible, Coinsurance Amount and Copayment Amount will not apply.
4. **Preventive Care** — Benefits will be provided for routine physical examinations, well-child care, hemocult test, pap smears, immunizations for Participants 8 years of age and over, routine lab, x-ray, vision and hearing examinations up to a \$300 combined Calendar Year maximum for Network and Out-of-Network Benefits.

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

Mammography screening, colorectal cancer screening and prostate cancer screening are not considered for benefits under this preventive care benefit.

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. The Deductible does not apply; however benefits will be subject to all other contractual provisions.
6. **Certain Therapies for Children with Developmental Delays** – Benefits are provided for a Dependent child under three years of age with development 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 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.

7. **Benefits for Mammography Screening** – Benefits are provided for female Participants 35 years of age or older for a routine screening by low-dose mammography for the presence of occult breast cancer except that benefits will not be available for more than one routine mammography screening each Calendar Year.

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

*Non routine-diagnostic mammograms are provided at 80% of the Allowable Amount after Calendar Year Deductible for Network and 70% of the Allowable Amount after Calendar Year Deductible for Out-of-Network Benefits.*

8. **Benefits for Certain Therapies for Colorectal Cancer** – Benefits for *Medical-Surgical Expense* incurred for a diagnostic medically recognized screening examination for the detection of colorectal cancer for Participants 50 years of age or older and who are at normal risk for developing colon cancer. Such Participant shall be entitled to benefits for (a) fecal occult blood test performed annually and flexible sigmoidoscopy performed every five years; or (b) Colonoscopy performed every ten years.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after Calendar Year Deductible	70% of the Allowable Amount after Calendar Year Deductible

9. **Benefits for Certain Tests for Detection of Prostate Cancer** – Benefits will be provided if a male Participant incurs *Medical-Surgical Expense* for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer. Such Participant shall be entitled to:
  - Physical examination for the detection of prostate cancer; and

- Prostate-specific antigen test used for the detection of prostate cancer for each male Participant under this Contract who is at least:
  - (a) 50 years of age and asymptomatic; or
  - (b) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

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

F. **Coinsurance Amounts** — 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 Coinsurance Amount is two times the individual Coinsurance Amount. No Participant will be allowed to satisfy more than the individual Coinsurance Amount toward the family Coinsurance Amount.

Options	Network Coinsurance Amounts	Out-of-Network Coinsurance Amounts
<i>Applicable to all Plans</i>		
Individual	\$3,000	\$6,000
Family	\$6,000	\$12,000

G. **Maximum Benefits** – The lifetime maximum of a Participant’s benefits is \$5,000,000.

H. **Organ and Tissue Transplant Benefit Maximum** – The lifetime maximum for organ and tissue transplants is \$300,000 for each Participant.

I. **Prescription Drug Program**

1. **Calendar Year Maximum** – There is a \$3,000 Calendar Year maximum for each Participant whether or not benefits are received at a Participating Pharmacy or Non-Participating Pharmacy.
2. **Copayment Amounts/Deductibles:** There is a \$3,000 Calendar Year maximum for each Participant whether or not benefits are received at a Participating Pharmacy, Non-Participating Pharmacy, or through the Mail Services Prescription Drug Program.

<b>PRESCRIPTION DRUG PROGRAM</b>			
Plan Features <i>Applicable to all Plans</i>			
<b>Deductible</b>	<b>\$200</b>		
<b>Calendar Year Maximum</b>	<b>\$3,000</b>		
<b>Copayment Amounts</b>	<b>Generic</b>	<b>Preferred Brand Name Drugs</b>	<b>Non-Preferred Brand Name Drugs</b>
<b>Retail Pharmacy</b>			
▪ 30-Day Supply on each occasion dispensed	\$10	\$30	\$45
▪ 90-Day Supply	\$30	\$90	\$135
<b>Mail Service</b>			
▪ 90-Day Supply	\$20	\$60	\$90

The amount of Your payment also depends on where Your prescription is filled and whether a Generic 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 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.

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 Contract 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).

3. ***Preferred Brand Name Drug List*** — You will receive a Preferred Brand Name Drug List at least annually. The list will be updated periodically to add new Preferred Brand Name Brand Drugs. You may also call the Customer Service Helpline to find out which drugs are on the list.

#### **IV. Limitations and Exclusions**

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

- **Preexisting 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; and
  - Whose most recent Creditable Coverage was under a group health plan, governmental plan or church plan.

If a Participant’s most recent prior Creditable Coverage was under a group plan, a governmental plan or a church plan, but he 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 Delays*.
- Custodial Care.
- Routine physical examinations (including a routine Pap smear), diagnostic screening, or immunizations, **except** (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*, and (7) *Certain Therapies for Children with Developmental Delays*, as provided in the Contract.
- 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 jawbone 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 described 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 Delays**.
- 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 Prescription Drug Program, that are: (1) dispensed by a Pharmacy and received by the Participant while covered under this Contract, (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 Contract.

*The benefits provided under the Prescription Drug Program 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 covered 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 Copayment Amount provided under this Contract.
- Infertility medication and fertility medication; prescription contraceptive devices, non-prescription contraceptive materials (**except** prescription oral contraceptive medications which are Legend Drugs. However, coverage for prescription contraceptive devices is covered 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 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).
- 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.
- 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-SELCHOICE-3 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 first day of each Contract 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 rate provided You is 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, a 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.