MEDICAL PLAN

SUMMARY PLAN
DESCRIPTION

As of August 1, 2017
WHO IS ELIGIBLE

Employee Eligibility

You are eligible to participate in the Plan if you:

• are a regular full-time employee of Andeavor or one of its participating subsidiaries (scheduled to work at least 30 hours per week);
• are not covered under a collective bargaining agreement (unless your collective bargaining agreement provides for participation in the Plan); and
• are on a U.S. payroll.

You are not eligible to participate in the Plan if you:

• are not a regular full-time employee (e.g., are a part-time, temporary or seasonal employee);
• are covered by a collective bargaining agreement that does not provide for participation in the Plan;
• are not on a U.S. payroll;
• are a leased employee, non-employee director or independent contractor; or
• are employed by a related company or any subsidiary or affiliate that has not adopted the Plan.

Dependent Eligibility

If you enroll for Plan coverage, you may also enroll your eligible dependents, as follows:

• your spouse (if you are not legally separated);
• your children under age 26. Dependent children include:
  – your biological children,
  – stepchildren, and
  – foster children or legally adopted children, including children placed with you for adoption for whom legal adoption proceedings have started even if not final;
  – children for which there is a court order establishing your legal guardianship or conservatorship, which has not been terminated by the parties or operation of law;
• your mentally or physically disabled dependent children of any age (see the box below); and
• your domestic partner and your domestic partner’s dependent children (see the information at the top of the next page).

CONTINUING COVERAGE FOR A DISABLED CHILD

Coverage for a child will not terminate upon reaching age 26 if the child continues to be both:

1. Disabled, and
2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin before the child attains age 26. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claim Administrator within 31 days following the child’s attainment of age 26. For new employees, such proof must be submitted in connection with your initial enrollment.

As a condition to the continued coverage of a child as a Disabled Dependent beyond age 26, the Claim Administrator may require periodic certification of the child’s physical or mental condition, but no more frequently than annually after the two-year period following the child’s attainment of age 26.

1 For a dependent who becomes ineligible due to attaining age 26, coverage will extend through the end of the month in which that dependent’s 26th birthday falls.
DOMESTIC PARTNER COVERAGE

Domestic partner coverage includes a domestic partner meeting the eligibility criteria listed on Andeavor’s Affidavit of Domestic Partnership. To qualify for benefits, you must register your domestic partnership with Andeavor by submitting a signed affidavit. This form is available through the Andeavor Benefit Center or may be downloaded from Andeavor’s intranet site (see Contacts).

You must enroll your domestic partner and his or her dependent children within the first 31 days of the date they meet the eligibility requirements (upon hire or completion of six months of the domestic partner relationship). If you don’t enroll within the 31-day period, you must wait until the next open enrollment period. Note, however, that dependent coverage for eligible domestic partners generally requires that the value of that coverage be included as taxable income to the participant.

PROOF OF DEPENDENT STATUS

When you add any dependent during enrollment, you will be required to submit the appropriate documents within 31 days of eligibility (marriage certificate, birth certificate, etc.) to provide proof of dependent status. This process will apply whether the dependent is being added during your initial eligibility period, annual open enrollment or due to a life event.

You must enroll a newly eligible dependent within the first 31 days after the life event (birth, adoption or marriage, etc.) leading to the eligibility. If you don’t enroll within the 31-day period, you must wait until the next open enrollment period to enroll the dependent. However, covered medical expenses incurred for a newborn child within the first 31 days of life will be covered regardless of whether you enroll the child.

- Log in to the Andeavor Benefit Center at tsocorp.com/benefits.
- Proceed through the enrollment event (New Hire, Life Event, Annual Enrollment).
- At the first screen, upload the appropriate document(s) to provide proof of dependent status for any dependents (including a spouse) that you plan to enroll. You may also fax or mail the documents according to the instructions on the screen.
- Review your personal information, then create your dependent records. To select your benefit plan and add dependents, click on “Change” at the “Review Elections” screen.
- At the “Medical Benefit Options” screen, select a plan from the available options then click “Next” to select the dependents you want covered. You must add dependents for each plan you elect. You will receive an “Accept/Deny” dependent verification message once you complete this step. Click “Accept” and make sure the documents are submitted within 31 days of eligibility.
- Your dependent’s enrollment will be confirmed once documents have been received and verified by the Andeavor Benefit Center (verification will be complete within three business days of receipt).

Enrollment of your dependents in the Plan will be pending until proof of dependent status has been received by the Andeavor Benefit Center. If the required documentation is not received within 31 days of eligibility, your dependents will not be added. Please contact the Andeavor Benefit Center with any questions.

Ineligible Dependents

The following persons are not eligible for dependent coverage under the Plan

- your legally separated spouse;
- a child who is employed by Andeavor or an affiliate,
- a child who no longer qualifies as a dependent because of age,
- a child who no longer qualifies as a dependent due to disability, or
- an individual who no longer qualifies as a child for whom you are the legal guardian or conservator.
HOW MEDICARE AFFECTS ELIGIBILITY

Active Employees

Coverage under the Plan is generally available to eligible active employees regardless of your age or entitlement to Medicare. If you are covered under the Plan as an employee when you reach age 65 or otherwise become entitled to Medicare Part A or Part B during your employment, the Plan will continue as your Primary coverage while you are an employee unless:

• you notify the Company in writing that you do not want the coverage to continue (within 31 days after you enroll in Medicare or during an open enrollment period); or

• you otherwise cease to be eligible for coverage under the Plan.

If the Plan is considered Primary, and Medicare coverage will be Secondary. See Coordination of Benefits (COB) section for more information on Primary coverage, Secondary coverage and how the Plan coordinates benefits with Medicare.

Eligible Dependents of Active Employees

Coverage under the Plan is available to your dependents even if they are entitled to Medicare. If your covered spouse reaches age 65 or an eligible dependent becomes entitled to Medicare, the Plan will continue as their Primary coverage until:

• you notify the Company within 31 days of the dependent’s Medicare enrollment or during the open enrollment period that you do not want the dependent’s coverage to continue; or

• the dependent otherwise ceases to be eligible for coverage under the Plan.

Notwithstanding the foregoing, if you or your dependents are eligible for or entitled to Medicare as a result of End Stage Renal Disease (ESRD), the Plan will become Secondary coverage as of the end of the first 30 months of such person’s eligibility or entitlement to Medicare.

Inactive LTD Participants

Coverage under the Plan is generally available to eligible inactive employees who are receiving benefits under a company sponsored Long Term Disability program, regardless of your age or entitlement to Medicare. If you are covered under the Plan as an inactive LTD participant when you reach age 65 or otherwise become entitled to Medicare Part A or Part B, the Plan will be considered Secondary, and Medicare coverage will be Primary. If you are entitled to Medicare Part A or Part B and do not enroll in Part A or Part B, the Plan will estimate Medicare coverage that would have been provided under Part A or Part B and coordinate with those estimated benefits. See Coordination of Benefits (COB) section for more information on Primary coverage, Secondary coverage and how the Plan coordinates benefits with Medicare.

Eligible Dependents of Inactive LTD Participants

Coverage under the Plan is available to your dependents even if they are entitled to Medicare. If your covered spouse reaches age 65 or an eligible dependent becomes entitled to Medicare, the Plan will be considered Secondary, and Medicare coverage will be Primary. If your dependent is entitled to Medicare Part A or Part B and does not enroll in Part A or Part B, the Plan will estimate Medicare coverage that would have been provided under Part A or Part B and coordinate with those estimated benefits.

ENROLLING IN THE PLAN

To complete your Medical Plan election, you’ll need to:

• choose from the Plan options available to you; and

• decide which of your eligible dependents you wish to cover, if any.

Generally, the coverage levels available under the Plan are:

• Employee Only;

• Employee + Child(ren);

• Employee + Spouse;

• Employee + Family; or

• Waive Coverage.
The coverage levels available to cover Domestic Partner and Domestic Partner Children under the Plan are:

- Employee + Spouse/Domestic Partner;
- Employee + Family (including Domestic Partner plus Child(ren) &/or Domestic Partner Child(ren)).

**IF YOUR SPOUSE IS ALSO AN ELIGIBLE EMPLOYEE**

If both you and your spouse are eligible to enroll in the Plan, you may elect Plan coverage as an employee and as a dependent spouse. Your coverage as a dependent spouse will be Secondary to your coverage as an employee. See Coordination of Benefits (COB) section for more information on Primary coverage and Secondary coverage. However, you may not receive coverage as both an employee and dependent child.

**Enrollment**

You must enroll yourself and your eligible dependents in the Plan within 31 days of your employment date, or within 31 days of the date you first become eligible for the Plan (if later). If you enroll within 31 days of your employment or eligibility date, your coverage is effective as of your eligibility date.

If you do not enroll within 31 days of your employment date or the date you first became eligible, you will be automatically enrolled in default coverage plans at the Employee Only coverage level.

If you decline (waive) coverage, you must wait until the next open enrollment period to change your elections, unless you become eligible to make an election change under the Plan as a result of an eligible status change.

You may enroll by completing your Online Benefits Enrollment through the Andeavor Benefit Center at tscorp.com/benefits or by calling (866) 787-6314. Coverage for your dependents will not be completed until you submit required documentation verifying eligibility.

After you have completed your enrollment, you should print a Confirmation Form verifying your elections. It is important for you to keep a copy of your enrollment elections to show proof of your elections should an issue later arise.

Your medical coverage will begin as of your eligibility date and any payroll deductions covering your elections will be made retroactively.

**Default Enrollment**

If you do not enroll within 31 days of your becoming eligible for benefits, you will be enrolled in the Value Plus Plan option at the Employee Only coverage level. The Value Plus Plan is considered a "high deductible health plan" under IRS rules.

**Annual Open Enrollment Period**

During an annual open enrollment period designated by the Company (normally in October of each year for coverage beginning the following January 1), you must make an election to enroll, re-enroll or decline (waive) participation for the coming year. You may change Medical Plan options or coverage levels and add/re-add dependents to your coverage. If you do not make an election during this period, you will receive the default employee-only coverage unless you have currently waived coverage. You will not be allowed to change that election before the next open enrollment period, unless you experience an eligible status change during the year.

Coverage elections (and deemed default elections) made during open enrollment become effective on January 1 of the immediately following year.
Special Enrollment

Certain family status changes (see Changes in Family Status) may allow for mid-year enrollment as a Special Enrollee. If you are applying for coverage as a Special Enrollee, you must do so within 31 days of the change. A person will be considered to be a Special Enrollee if all of the following apply:

• you did not elect medical coverage for that person within 31 days of the date the person first became eligible (or during an open enrollment period), because the person had medical coverage from another source; and
• the person loses such coverage because:
  – of termination of employment resulting in loss of coverage,
  – of reduction in hours of employment resulting in loss of coverage,
  – your spouse dies,
  – you and your spouse divorce or become legally separated,
  – the medical coverage was COBRA continuation and the continuation is exhausted, or
  – the other plan terminates due to the employer’s failure to pay the premium or any other reason; and
• you elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

In addition, you will be a Special Enrollee if you obtain a new dependent through birth, adoption or marriage, and you elect coverage for that person within 31 days of the date you obtain the new dependent.

WHEN COVERAGE BEGINS

Your coverage under the Plan begins as follows:

<table>
<thead>
<tr>
<th>If you enroll ...</th>
<th>Coverage for you and your enrolled dependents begins ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 31 days of employment</td>
<td>On your eligibility date</td>
</tr>
<tr>
<td>Within 31 days of your initial eligibility date</td>
<td>On your eligibility date</td>
</tr>
<tr>
<td>During the open enrollment period</td>
<td>On January 1 of the following year</td>
</tr>
<tr>
<td>Within 31 days of an eligible status change (see Changing Your Coverage)</td>
<td>On the effective date of the status change (unless otherwise prohibited by applicable law)</td>
</tr>
</tbody>
</table>

CHANGING YOUR COVERAGE

After your initial enrollment, you can make changes to your coverage only during the open enrollment period or as the result of an eligible status change or other permissible event.

An eligible status change includes a change during the Plan Year in the following:

• your family status; or
• your or your spouse’s employment status.

You must request any changes to your coverage within 31 days of the eligible status change or other permissible event.

You may complete the change event online in the Andeavor Benefit Center portal at tsocorp.com/benefits or request a change by calling (866) 787-6314 within 31 days of the change.
An eligible status change allows you to:

- change your level of coverage (for example, from “Employee Only” to “Employee + Spouse” coverage);
- elect coverage if you previously waived coverage;
- terminate coverage; or
- change your benefit option (for example, from the PPO Base Plan to the Value Plus Plan).

Changes in your Plan coverage must be consistent with the status change. For example, you may change your benefit option if your status change is relocation to a different network service area that your current benefit option does not cover.

Changes to your coverage and any change in your required contributions will take effect as of the date of the event (unless otherwise prohibited by applicable law.)

Changes in Family Status

An eligible change in family status includes:

- marriage;
- divorce or legal separation from your spouse;
- completion of six months in a domestic partnership;
- termination of a domestic partnership;
- birth, adoption or placement for adoption of a dependent child;
- establishment or termination of legal guardianship or conservatorship of a child;
- death of a spouse or a dependent child;
- loss of dependent eligibility; or
- acquiring a dependent who was not eligible for coverage during the previous open enrollment period and later becomes eligible during a Plan Year.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCOS)

The Plan will provide coverage for your eligible child pursuant to the terms of a Qualified Medical Child Support Order (QMCSO), regardless of any enrollment season restrictions that might otherwise apply, even if:

- you do not have legal custody of the child; or
- the child is not dependent on you for support.

A QMCSO is an order from a state court or other state agency, usually issued as a part of a settlement agreement or divorce decree, that provides for health care coverage for the child of a Plan participant. A QMCOS must meet certain legal requirements to be considered “qualified.”

You are required to be enrolled in the Plan in order to enroll your eligible child.

If the Plan receives a valid QMCOS and you do not enroll the dependent child, the custodial parent or state agency may enroll the affected child. Andeavor may withhold the contributions required for the child’s coverage from your pay.

A copy of the Plan’s QMCSO procedures is available, free of charge, upon request to the Andeavor Benefit Center.
Changes in Employment Status

An eligible change in employment status includes the following for you, your spouse or your dependent child if the change affects the person’s eligibility for coverage under the Plan:

- a Company-authorized transfer or relocation requiring a change in work location and relocation of your residence;
- employment or unemployment (i.e., new job or loss of a job); or
- a change in work schedule (i.e., a reduction or increase in hours, a switch between part-time and full-time, strike or lockout, commencement or return from unpaid leave of absence).

Other Permissible Events

You may make certain changes to your coverage during the Plan Year upon the occurrence of the following events:

- the receipt of a qualified medical child support order with respect to your child;
- a significant increase in the cost of the benefit option;
- a significant curtailment of coverage under the benefit option; or
- loss of coverage under another employer plan or coverage sponsored by a governmental or educational institution.

COST OF COVERAGE

You and the Company share the cost of medical coverage for you and your eligible dependents. Your cost is based on the coverage option and level of coverage you choose. You generally pay for coverage on a pre-tax basis. However, dependent coverage for eligible domestic partners (and their children) generally requires that the value of that coverage be included as income to the participant. The contribution amount for each coverage option and level of coverage is subject to change and is announced in advance.

HOW THE MEDICAL PLAN WORKS

Andeavor Corporation offers a variety of medical options administered by BlueCross BlueShield of Texas (BCBSTX). The options available to you depend on where you live or work:

<table>
<thead>
<tr>
<th>Most Locations excluding Utah and Wyoming Standard Medical Options</th>
<th>Utah and Wyoming Traditional Medical Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>• PPO Base Plan</td>
<td>• Traditional PPO</td>
</tr>
<tr>
<td>• Value Plus Plan with HSA</td>
<td>• Traditional Value Plus Plan with HSA</td>
</tr>
<tr>
<td>• An Out-of-Area Plan is available in all states if your home zip code is not in the managed care plan service area</td>
<td></td>
</tr>
</tbody>
</table>

Local/Regional Medical Options

In some locations, additional local or regional Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO) options may be available. You must generally live or work in the local plan’s service area and benefits may be limited or excluded outside the service area. Local plan provisions may be different than the detailed plan provisions described in this booklet. For detailed information on local or regional coverage options, you should review the benefit booklet (sometimes called a “certificate of coverage”) provided by the insurance company. The benefit booklet explains eligibility, covered services, prescription drugs, supplies and treatment, and lists providers currently associated with your coverage. It also explains how to obtain care, file a claim (if necessary) and appeal a claim. If a local or regional option is offered in your area, you will see it in your personalized online Benefits Enrollment Worksheet.

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*The various local health plans offered by Andeavor are Constituent Benefit Programs of the Andeavor Omnibus Group Welfare Benefits Plan.*
STANDARD MEDICAL PLAN OPTIONS – Most Locations, excluding Utah and Wyoming

Two Options: PPO Base Plan and Value Plus Plan with HSA

With both options, you have the choice of receiving benefits from an in-network provider or an out-of-network provider. You will pay less when you use in-network providers; and both plans use the Blue Choice Network, which provides you access to a large, nationwide network of physicians.

- If you choose an in-network doctor or hospital, you will pay less for covered services because they have agreed to provide services at an amount set out in a provider contract (the contracting Allowable Amount).
- If you go to an out-of-network provider, your fees may be higher and the Plan will cover less of the cost. Out-of-network providers are not contractually bound to limit the amount of their charges for services and may balance bill you for the charges not covered by the Plan. The amounts charged by an out-of-network provider that exceed the non-contracting Allowable Amount are not covered expenses under the Plan, and they do not accumulate toward your deductible or out-of-pocket maximum. You may have to submit claims for the services provided, and you will be responsible for paying:
  - Billed charges above the non-contracting Allowable Amount as determined by the Claim Administrator,
  - Coinsurance amounts and deductibles, at the out-of-network level (which will be applied to the Out-of-Pocket Maximum),
  - Limited or non-covered services, and
  - Failure to Preauthorize penalty.

- You are encouraged, but not required, to select a Primary Care Physician (PCP) from the Plan’s network of providers to provide all non-specialty care. Each covered family member may select his or her own PCP. PCPs include general practitioners, family physicians, internists, gynecologists and pediatricians.
- You can choose to see a specialist anytime, without a referral.
- In-network preventive care is covered at 100%.
- Once the amount you pay for covered expenses reaches your annual out-of-pocket maximum, the Plan will pay 100% of eligible covered expenses for the remainder of the year.

How the two options are different

<table>
<thead>
<tr>
<th>PPO Base Plan</th>
<th>Value Plus Plan with HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For all eligible care, except preventive, you pay either a flat dollar amount (called a copay) or a combination of annual deductible and coinsurance.</td>
<td></td>
</tr>
<tr>
<td>• Deductibles and out-of-pocket maximums are based on person receiving care.</td>
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</tr>
<tr>
<td>• Prescription Drug Benefits - automatically included (see Prescription Drug Benefit).</td>
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<tr>
<td>• For all eligible care, except preventive, you pay 100% of the cost until the annual deductible for your level of coverage is met. After that, you pay the applicable coinsurance amount.</td>
<td></td>
</tr>
<tr>
<td>• Deductibles and out-of-pocket maximums work differently — and are determined by the coverage level in which you are enrolled. For more information, see Calendar Year Deductible.</td>
<td></td>
</tr>
<tr>
<td>• Prescription Drug Benefit - automatically included. However, the Value Plus Plan does not generally begin paying benefits for prescription drugs until after the annual deductible has been met. There is an exception to this provison for Preventive Drug List Drugs, which are covered, subject to coinsurance, prior to the deductible being met (see Prescription Drug Benefit).</td>
<td></td>
</tr>
</tbody>
</table>
**THE BLUECHOICE® NETWORK**

BCBSTX offers an extensive nationwide network of doctors, hospitals and other health care providers in all states where they operate. You save money when you receive care through an In-Network provider.

**How to find a BCBSTX Network Provider:**

**Online** — Go to bcbstx.com and select Provider Finder in the Find a Doctor section.

• Select BlueChoice® PPO under Network.

• Select the state you live in or the state in which you are seeking a provider. **Note:** Depending on state selection (CA, WA, ID, PA), you may be asked to enter your alpha prefix, or the first three letters of your member ID. Your alpha prefix is TEZ.

• Select Provider Type and/or enter the name of the doctor, facility or other health care provider. You may narrow your search further by entering an address, city and zip.

**On your mobile device** — Go to bcbstx.com from your mobile phone’s Web browser and click on Find a Doctor or Hospital. Or download the Provider Finder app for your iPhone® or Android® phone. If you use your GPS location or input a ZIP code, the app can pinpoint the closest provider locations for you.

**On the phone** — Call (800) 521-2227 to speak to a customer service advocate.

For more information regarding In-Network Providers under the Plan, contact the Andeavor Benefit Center. Provider lists are furnished automatically upon request, without charge.

If you are enrolled in an option that offers a choice and you want to use in-network benefits, it is your responsibility to ensure that the physician or facility is a participating network or ParPlan provider. Be sure to present your Medical Plan ID card and identify yourself as a Plan member every time you visit a provider.

**GOING OUT-OF-NETWORK**

Out-of-network providers are providers who are not part of the BlueChoice® Network and have not agreed to accept the contracting Allowable Amount for covered services. If you are in the PPO Base Plan and you obtain any services from an out-of-network provider or facility, you will receive a reduced benefit from the Plan. You will be responsible for paying:

• Billed charges above the non-contracting Allowable Amount as determined by the Claim Administrator,

• Copays, coinsurance amounts and deductibles at the out-of-network level,

• Limited or non-covered services, and

• Failure to Preauthorize penalty.

In addition, you may be responsible for submitting claims to the Plan for the services provided by an out-of-network provider. Some out-of-network providers, however, participate in ParPlan, which is a direct payment arrangement between an out-of-network provider and the Claims Administrator to permit simpler processing of out-of-network claims. When you consult a provider who does not participate in the Network, you should inquire if the provider participates in the Claim Administrator’s ParPlan.

**What is the BlueCross BlueShield of Texas ParPlan?**

ParPlan is a contractual arrangement with physicians and other health care professionals not currently in the BlueChoice® network who agree to:

• Contracted Allowed Amounts

• File members’ claims

• Cooperate with Blue Cross and Blue Shield of Texas’ utilization review activities

**When you visit a ParPlan provider, you:**

• Pay your deductible and coinsurance, when applicable

• May have to precertify your own care when required

• Avoid paperwork because claims are generally filed for you
OUT-OF-AREA PLAN

If you live in an area that does not have reasonable access to the Plan’s network providers, you are eligible for the Out-of-Area Plan. This option is a traditional medical plan with most eligible expenses subject to an annual deductible and coinsurance. Following are highlights of this option:

• Once you have met your deductible, the Plan will pay 80% of eligible expenses; you pay the other 20% (your coinsurance) until you meet your out-of-pocket maximum. Preventive care is not subject to the deductible.

• Once the amount that you pay reaches the out-of-pocket maximum, the Plan will pay 100% of eligible covered expenses.

• The Prescription Drug Benefit is automatically included (see Prescription Drug Benefit).

• Under this option, if the physician or facility you use is a member of the network that has agreed to accept the contracting Allowable Amount for covered services, you will continue to receive benefits under the Out-of-Area Plan design, but your charges will be based on the contracting Allowable Amount.

You may have to submit claims for any services provided and you will be responsible for:

• Billed charges above the contracting Allowable Amount as determined by the Claim Administrator,

• Co-share amounts and deductibles

• Limited or non-covered services, and

• Failure to Preauthorize penalty.

WHAT IS COVERED UNDER THE PLAN

The summary charts on the following pages highlight some of the medical services and supplies that are covered under the Medical Plan. For items that are marked with an asterisk, see What’s Covered for more detailed information — including full benefit descriptions, explanations and limitations.
Standard Medical Plan Summary Chart
Deductible applies unless indicated otherwise.

<table>
<thead>
<tr>
<th>General Information</th>
<th>PPO Base Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Deductible&lt;sup&gt;2&lt;/sup&gt;</td>
<td>$750 per person; $2,250 per family</td>
<td>$1,000 per person; $3,000 per family</td>
<td>$1,500 per person (individual coverage); $3,000 per family (other than individual coverage)</td>
</tr>
<tr>
<td>Calendar Year Out-of-Pocket Maximum&lt;sup&gt;3&lt;/sup&gt;</td>
<td>$2,250 per person; $4,500 per family</td>
<td>$3,000 per person; $6,000 per family</td>
<td>$4,000 per person (individual coverage); $8,000 per family (other than individual coverage)</td>
</tr>
</tbody>
</table>

**Preventive Services**

<table>
<thead>
<tr>
<th></th>
<th>PPO Base Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
</tr>
<tr>
<td><em>Routine Cancer Screenings</em>&lt;sup&gt;4&lt;/sup&gt;</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
</tr>
<tr>
<td></td>
<td>Includes annual mammogram, pap smear, gynecological exam, fecal occult blood test, digital rectal exam and PSA test; additional screenings covered after age 50.</td>
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<td></td>
</tr>
<tr>
<td>*Routine Physical Exams&lt;sup&gt;5&lt;/sup&gt;</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
</tr>
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<td></td>
<td>Includes adult physical exams; well-child visits; screening and counseling for obesity, misuse of alcohol/drugs and tobacco; lab/X-ray and TB testing.</td>
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</tr>
</tbody>
</table>

**Emergency or Urgent Services**

<table>
<thead>
<tr>
<th></th>
<th>PPO Base Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Ambulance Emergency&lt;sup&gt;6&lt;/sup&gt;</td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>*Emergency Room&lt;sup&gt;7&lt;/sup&gt;</td>
<td>$100 copay per visit (waived if admitted to hospital), then 0% with no deductible</td>
<td>$100 copay per visit (waived if admitted to hospital), then 0%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td>$250 copay per visit (waived if admitted to hospital) then 10% with no deductible</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>*Urgent Care Facility, Retail Health Clinic or Provider Non-hospital free standing facility&lt;sup&gt;8&lt;/sup&gt;</td>
<td>$25 copay per visit, then 0% with no deductible</td>
<td>$25 copay per visit, then 0%</td>
<td>20%</td>
</tr>
</tbody>
</table>

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<sup>1</sup> For out-of-network/non-participating benefits, you will pay your percentage of the cost based on the non-contracted Allowable Amount plus 100% of any excess amount above the non-contracted Allowable Amount (see Allowable Amounts).

<sup>2</sup> See Calendar Year Deductible for information on what’s included and not included in the deductible.

<sup>3</sup> Excludes certain expenses such as non-covered expenses, preauthorization penalties and amounts in excess of Allowable Amounts. See Calendar Year Out-of-Pocket Maximum for details. For Value Plus Plan participants, no one family member will have to pay more than $4,000 toward covered expenses in a single year.

<sup>4</sup> When receiving out-of-network services, you should call BCBSTX to preauthorize treatment before receiving care to avoid a reduction in benefits. See Preauthorization Requirements for more information.

<sup>5</sup> See What’s Covered for other important information.
## Standard Medical Plan Summary Chart (continued)

<table>
<thead>
<tr>
<th>Outpatient Services</th>
<th>PPO Base Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Area Benefits</td>
<td>No Preferred Providers in your area</td>
<td>In-Network Area Benefits</td>
</tr>
<tr>
<td><em>Chiropractic and Spinal Manipulation Treatment</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 15 visits per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$25 copay, no deductible</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td><em>Diagnostic Lab/X-Ray</em></td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Includes radiological and complex imaging.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Doctor's Office Visits</em></td>
<td>$25 copay, no deductible</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Non-preventive, non-surgical visits. Includes allergy testing, treatment and injections. Does not include routine physical exams or cancer screenings.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Outpatient Surgery and Physician Surgical Services</em></td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Prenatal Office Visits</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Walk-in Clinic Visits</em></td>
<td>$25 copay, no deductible</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td><em>Mental Health and Substance Abuse Services</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient*</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient (office visits)</td>
<td>$25 copay, no deductible</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Inpatient Hospital Stay and Services</em> 4</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Includes room and board at the semi-private rate, surgeon’s and physician’s fees, lab/X-ray and other hospital services and supplies.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Pregnancy Related Expenses</em> 5 — Hospital Facility</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Covered expenses include charges made by a physician for pregnancy and childbirth services and supplies at the same level as any illness or injury. Covered for a minimum of 48 hours after vaginal delivery and 96 hours after cesarean delivery.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Newborn Child Hospital Facility Expenses</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
</tr>
</tbody>
</table>

---

1 For out-of-network benefits, you will pay your percentage of the cost based on the non-contracted Allowable Amount plus 100% of any excess amount above the non-contracted Allowable Amount (see Allowable Amounts).
2 See Calendar Year Deductible for information on what’s included and not included in the deductible.
3 Excludes certain expenses such as non-covered expenses, preauthorization penalties and amounts in excess of Allowable Amounts. See Calendar Year Out-of-Pocket Maximum for details. For Value Plus Plan participants, no one family member will have to pay more than $4,000 toward covered expenses in a single year.
4 When receiving out-of-network services, you should call BCBS of Texas to preauthorize treatment before receiving care to avoid a reduction in benefits. See Preauthorization Requirements for more information.
5 See What’s Covered for other important information.
### Standard Medical Plan Summary Chart (continued)

<table>
<thead>
<tr>
<th>Alternatives to Hospital Stays</th>
<th>PPO Base Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network (Preferred Providers)</td>
<td>Out-of-Network¹ (Non-Preferred Providers)</td>
<td>No Preferred Providers in your area</td>
</tr>
<tr>
<td><strong>Home Health Care</strong>²</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Limited to 60 visits per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice Care</strong>²</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Inpatient or outpatient.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Private Duty Nursing</strong>²</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Limited to 70 shifts per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong>²</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Limited to 60 days per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Therapy Services

<table>
<thead>
<tr>
<th>Therapy Services</th>
<th>PPO Base Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acupuncture Therapy</strong></td>
<td>In lieu of anesthesia: $25 copay, no deductible Other than in lieu of anesthesia: 20%</td>
<td>In lieu of anesthesia: 30% Other than in lieu of anesthesia: 20%</td>
<td>In lieu of anesthesia: 30% Other than in lieu of anesthesia: 20%</td>
</tr>
<tr>
<td>Limited to 5 visits per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Short-Term Rehabilitation Therapy</strong></td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Includes outpatient physical, occupational, speech and cognitive therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialized Care</strong></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td>Includes chemotherapy, radiation therapy and outpatient infusion therapy.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Transplant Coverage

<table>
<thead>
<tr>
<th>Transplant Coverage</th>
<th>PPO Base Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Travel Benefits</strong>²</td>
<td>Coverage of $50/ person/night for patient and one companion; Coach air fare; $10,000 maximum per transplant for travel and lodging.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Travel and lodging expenses for transplant patients and a companion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplant Services</strong>²</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ For out-of-network benefits, you will pay your percentage of the cost based on the non-contracted Allowable Amount plus 100% of any excess amount above the non-contracted Allowable Amount (see Allowable Amounts).
² See Calendar Year Deductible for information on what’s included and not included in the deductible.
³ Excludes certain expenses such as non-covered expenses, preauthorization penalties and amounts in excess of Allowable Amounts. See Calendar Year Out-of-Pocket Maximum for details. For Value Plus Plan participants, no one family member will have to pay more than $4,000 toward covered expenses in a single year.
⁴ When receiving out-of-network services, you should call BCBSTX to preauthorize treatment before receiving care to avoid a reduction in benefits. See Preauthorization Requirements for more information.
⁵ See What’s Covered for other important information.
### Standard Medical Plan Summary Chart (continued)

<table>
<thead>
<tr>
<th>Other Covered Services</th>
<th>PPO Base Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Area Benefits</strong></td>
<td><strong>In-Network (Preferred Providers)</strong></td>
<td><strong>Out-of-Network(^1) (Non-Preferred Providers)</strong></td>
<td><strong>In-Network (Preferred Providers)</strong></td>
</tr>
<tr>
<td><em>Diabetic Equipment, Supplies and Education</em></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Durable Medical Equipment</em></td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td><em>Obesity Treatment</em> Limited to Medically Necessary treatment only</td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
<tr>
<td><em>Oral and Maxillofacial Treatment</em> Medical treatment of the mouth, jaws and teeth.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><em>Prosthetic Devices</em></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td><em>Reconstructive or Cosmetic Surgery and Supplies</em></td>
<td>10%</td>
<td>30%</td>
<td>20%</td>
</tr>
</tbody>
</table>

\(^1\) For out-of-network benefits, you will pay your percentage of the cost based on the non-contracted Allowable Amount plus 100% of any excess amount above the non-contracted Allowable Amount (see Allowable Amounts).

\(^2\) See Calendar Year Deductible for information on what’s included and not included in the deductible.

\(^3\) Excludes certain expenses such as non-covered expenses, preauthorization penalties and amounts in excess of Allowable Amounts. See Calendar Year Out-of-Pocket Maximum for details. For Value Plus Plan participants, no one family member will have to pay more than $4,000 toward covered expenses in a single year.

\(^4\) When receiving out-of-network services, you should call BCBS TX to preauthorize treatment before receiving care to avoid a reduction in benefits. See Preauthorization Requirements for more information.

\(^5\) See What’s Covered for other important information.
TRADITIONAL MEDICAL PLAN OPTIONS – *Only available to employees living or working in Utah and Wyoming*

Two Options: Traditional Plan and Traditional Value Plus Plan with HSA

With both options, you have the choice of receiving benefits from a participating (PAR) provider or a non-participating (out-of-network) provider. You will pay less when you use participating providers. The Traditional Plans use the Blue Cross Blue Shield PAR Provider Network, which provides you access to a large, nationwide network of physicians.

- If you choose a PAR Provider (in-network) doctor or hospital, you will pay less for covered services because they have agreed to provide services at an amount set out in a provider contract (the contracting Allowable Amount).
- If you go to a non-PAR Provider (out-of-network) provider, your fees may be higher and the Plan will cover less of the cost. Out-of-network providers are not contractually bound to limit the amount of their charges for services and may balance bill you for the charges not covered by the Plan. The amounts charged by an out-of-network provider that exceed the non-contracting Allowable Amount are not covered expenses under the Plan, and they do not accumulate toward your deductible or out-of-pocket maximum. You may have to submit claims for the services provided, and you will be responsible for paying:
  - Billed charges above the non-contracting Allowable Amount as determined by the Claim Administrator,
  - Coinsurance amounts and deductibles, at the out-of-network level (which will be applied to the Out-of-Pocket Maximum),
  - Limited or non-covered services, and
  - Failure to Preauthorize penalty.

- You are encouraged, but not required, to select a Primary Care Physician (PCP) from the Plan’s network of providers to provide all non-specialty care. Each covered family member may select his or her own PCP. PCPs include general practitioners, family physicians, internists, gynecologists and pediatricians.
- In-network preventive care is covered at 100%.
- You can choose to see a specialist anytime, without a referral.
- Once the amount you pay for covered expenses reaches your annual out-of-pocket maximum, the Plan will pay 100% of eligible covered expenses for the remainder of the year.

How the two options are different

<table>
<thead>
<tr>
<th>Traditional Plan</th>
<th>Traditional Value Plus Plan with HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For all eligible care, except preventive, you pay either a flat dollar amount (called a copay) or a combination of annual deductible and coinsurance.</td>
<td>• For all eligible care, except preventive, you pay 100% of the cost until the annual deductible for your level of coverage is met. After that, you pay the applicable coinsurance amount.</td>
</tr>
<tr>
<td>• Deductibles and out-of-pocket maximums are based on person receiving care.</td>
<td>• Deductibles and out-of-pocket maximums work differently — and are determined by the coverage level in which you are enrolled. For more information, see Calendar Year Deductible.</td>
</tr>
<tr>
<td>• Prescription Drug Benefits - automatically included (see Prescription Drug Benefit).</td>
<td>• Prescription Drug Benefit - automatically included. However, the Value Plus Plan does not generally begin paying benefits for prescription drugs until after the annual deductible has been met. There is an exception to this provision for Preventive Drug List Drugs, which are covered, subject to coinsurance, prior to the deductible being met (see Prescription Drug Benefit).</td>
</tr>
</tbody>
</table>
BCBSTX PAR PROVIDER NETWORK – UTAH AND WYOMING

You save money when you receive care through a participating (in-network) provider.

How to find a BCBS PAR Provider

When you register with your BCBS ID card and log in at bcbstx.com, you’ll automatically be directed to participating providers in your area when using the provider search.

If you aren’t yet registered on bcbstx.com, you can still locate providers specific to your plan with the following steps:

1. Go to bcbstx.com on your computer or smartphone.
2. Select “Find a Doctor or Hospital”
3. Select “Search Now” at the bottom left of the page
4. Select your state (Utah or Wyoming) from the drop down menu on the left and click “Start Search”
5. Choose “ParPlan [PAR]” from the listed Plan Networks
6. Enter an address and provider name, type and/or specialty under “Search Criteria”
7. You can also call a BCBS Benefits Value Advisor at (800) 521-2227 for assistance

For more information regarding In-Network Providers under the Plan, contact the Andeavor Benefit Center. Provider lists are furnished automatically upon request, without charge.

Be sure to present your Medical Plan ID card and identify yourself as a Plan member every time you visit a provider.

GOING OUT-OF-NETWORK / USING NON-PARTICIPATING PROVIDERS

Providers who are not part of the network and have not agreed to accept the contracting Allowable Amount for covered services are called non-participating or out-of-network providers. If you are in the Traditional Plan or the Traditional Value Plus Plan and you obtain any services from an out-of-network provider or facility, you receive reduced benefit from the Plan and are responsible for paying:

- Billed charges above the non-contracting Allowable Amount as determined by the Claim Administrator,
- Copays, coinsurance amounts and deductibles at the out-of-network level,
- Limited or non-covered services, and
- Failure to Preauthorize penalty.

In addition, you may be responsible for submitting claims to the Plan for the services provided by an out-of-network provider.

OUT-OF-AREA PLAN

If you live in an area that does not have reasonable access to the Plan’s network providers, you are eligible for the Out-of-Area Plan. This option is a traditional medical plan with most eligible expenses subject to an annual deductible and coinsurance. See the specific separate section titled Out-of-Area Plan for more information on Out-Of Area benefits.

WHAT IS COVERED UNDER THE PLAN

The summary charts on the following pages highlight some of the medical services and supplies that are covered under the Medical Plan. For items that are marked with an asterisk, see What's Covered for more detailed information — including full benefit descriptions, explanations and limitations.
Traditional Medical Plan Summary Chart

Deductible applies unless indicated otherwise.

<table>
<thead>
<tr>
<th></th>
<th>Traditional Plan</th>
<th>Out-of-Area Plan</th>
<th>Traditional Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In-Network Area Benefits</strong></td>
<td><strong>Traditional Plan</strong></td>
<td><strong>Out-of-Network Plan</strong></td>
<td><strong>Traditional Value Plus Plan</strong></td>
</tr>
<tr>
<td><strong>In-Network Providers</strong></td>
<td>$750 per person; $2,250 per family</td>
<td>$750 per person; $2,250 per family</td>
<td>$1,000 per person; $3,000 per family</td>
</tr>
<tr>
<td><strong>Out-of-Network Providers</strong></td>
<td>$1,000 per person; $3,000 per family</td>
<td>$1,500 per person (individual coverage); $3,000 per family (other than individual coverage)</td>
<td>$1,500 per person (individual coverage); $3,000 per family (other than individual coverage)</td>
</tr>
</tbody>
</table>

**General Information**
- **Calendar Year Deductible**:
  - Traditional: $750 per person; $2,250 per family
  - Value Plus: $1,000 per person; $3,000 per family

**Calendar Year Out-of-Pocket Maximum**:
- Traditional: $2,250 per person; $4,500 per family
- Value Plus: $3,000 per person; $6,000 per family

**Preventive Services**
- **Immunizations**: 0%, no deductible
- **Routine Cancer Screenings** (includes annual mammogram, pap smear, gynecological exam, fecal occult blood test, digital rectal exam and PSA test; additional screenings covered after age 50): 0%, no deductible
- **Routine Physical Exams** (includes adult physical exams; well-child visits; screening and counseling for obesity, misuse of alcohol/drugs and tobacco; lab/X-ray and TB testing): 0%, no deductible

**Emergency or Urgent Services**
- **Ambulance** (Emergency):
  - Traditional: 10%
  - Value Plus: 10%
- **Emergency Room**:
  - Traditional: $100 copay per visit (waived if admitted to hospital), then 0% with no deductible
  - Value Plus: $100 copay per visit (waived if admitted to hospital), then 0% with no deductible
- **Non-Emergency Care in the Emergency Room**:
  - Traditional: $250 copay per visit (waived if admitted to hospital) then 10% with no deductible
  - Value Plus: $250 copay per visit (waived if admitted to hospital) then 10% with no deductible
- **Urgent Care Facility, Retail Health Clinic or Provider Non-hospital free standing facility**:
  - Traditional: $25 copay per visit, then 0% with no deductible
  - Value Plus: $25 copay per visit, then 0% with no deductible

---

1. For out-of-network/non-participating benefits, you will pay your percentage of the cost based on the non-contracted Allowable Amount plus 100% of any excess amount above the non-contracted Allowable Amount (see Allowable Amounts).
2. Calendar Year Deductible for information on what’s included and not included in the deductible.
3. Excludes certain expenses such as non-covered expenses, preauthorization penalties and amounts in excess of Allowable Amounts. See Calendar Year Out-of-Pocket Maximum for details. For Value Plus Plan participants, no one family member will have to pay more than $4,000 toward covered expenses in a single year.
4. When receiving out-of-network services, you should call BCBSTX to preauthorize treatment before receiving care to avoid a reduction in benefits. See Preauthorization Requirements for more information.
5. See What’s Covered for other important information.
### Traditional Medical Plan Summary Chart (continued)

<table>
<thead>
<tr>
<th></th>
<th>In-Network Area Benefits</th>
<th>Out-of-Network² (Non-Participating Providers)</th>
<th>No Participating Providers in your area</th>
<th>In-Network (Participating Providers)</th>
<th>Out-of-Network¹ (Non-Participating Providers)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Chiropractic and Spinal Manipulation Treatment</em></td>
<td>$25 copay, no deductible</td>
<td>$25 copay, no deductible</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Lab/X-Ray</strong></td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Doctor’s Office Visits</strong></td>
<td>$25 copay, no deductible</td>
<td>$25 copay, no deductible</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Surgery and Physician Surgical Services</strong></td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal Office Visits</strong></td>
<td></td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>10%</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Walk-in Clinic Visits</em></td>
<td>$25 copay, no deductible</td>
<td>$25 copay, no deductible</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health and Substance Abuse Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td>$250 penalty for failure to preauthorize services</td>
<td>$250 penalty for failure to preauthorize services</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Pregnancy Related Expenses</strong> — Hospital Facility</td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Newborn Child Hospital Facility Expenses</strong></td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
<td>0%, no deductible</td>
</tr>
</tbody>
</table>

¹ For out-of-network benefits, you will pay your percentage of the cost based on the non-contracted Allowable Amount plus 100% of any excess amount above the non-contracted Allowable Amount (see Allowable Amounts).

² See Calendar Year Deductible for information on what’s included and not included in the deductible.

³ Excludes certain expenses such as non-covered expenses, preauthorization penalties and amounts in excess of Allowable Amounts. See Calendar Year Out-of-Pocket Maximum for details. For Value Plus Plan participants, no one family member will have to pay more than $4,000 toward covered expenses in a single year.

⁴ When receiving out-of-network services, you should call BCBSTX to preauthorize treatment before receiving care to avoid a reduction in benefits. See Preauthorization Requirements for more information.

* See What’s Covered for other important information.
### Traditional Medical Plan Summary Chart (continued)

<table>
<thead>
<tr>
<th>Alternatives to Hospital Stays</th>
<th>Traditional Plan</th>
<th>Out-of-Area Plan</th>
<th>Traditional Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Home Health Care</em>&lt;sup&gt;4&lt;/sup&gt;</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Limited to 60 visits per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Hospice Care</em>&lt;sup&gt;4&lt;/sup&gt;</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Inpatient or outpatient.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Private Duty Nursing</em>&lt;sup&gt;4&lt;/sup&gt;</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Limited to 70 shifts per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Skilled Nursing Facility</em>&lt;sup&gt;4&lt;/sup&gt;</td>
<td>10%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Limited to 60 days per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Therapy Services

| *Acupuncture Therapy*<sup>4</sup> | In lieu of anesthesia: $25 copay, no deductible | In lieu of anesthesia: $25 copay, no deductible | In lieu of anesthesia: 10% Other than in lieu of anesthesia: 20% | In lieu of anesthesia: 10% Other than in lieu of anesthesia: 20% |
| Limited to 5 visits per year.    | Other than in lieu of anesthesia: 20%          | Other than in lieu of anesthesia: 20%          |                  |                  |

| *Short-Term Rehabilitation Therapy*<sup>4</sup> | 10% | 20% | 10% | 10% |
| Includes outpatient physical, occupational, speech and cognitive therapy. |                  |                  |                  |                  |

| *Specialized Care*<sup>4</sup> | Payable in accordance with the type of expense incurred and the place where service is provided. | Payable in accordance with the type of expense incurred and the place where service is provided. | 20% | 10% |
| Includes chemotherapy, radiation therapy and outpatient infusion therapy. |                  |                  |                  |                  |

### Transplant Coverage

| *Travel Benefits*<sup>4</sup> | Coverage of $50/ person/night for patient and one companion; Coach air fare; $10,000 maximum per transplant for travel and lodging. |                  |                  |                  |
| Travel and lodging expenses for transplant patients and a companion. |                  |                  |                  |                  |

| *Transplant Services*<sup>4</sup> | Payable in accordance with the type of expense incurred and the place where service is provided. |                  |                  |                  |

---

<sup>1</sup> For out-of-network benefits, you will pay your percentage of the cost based on the non-contracted Allowable Amount plus 100% of any excess amount above the non-contracted Allowable Amount (see Allowable Amounts).

<sup>2</sup> See Calendar Year Deductible for information on what’s included and not included in the deductible.

<sup>3</sup> Excludes certain expenses such as non-covered expenses, preauthorization penalties and amounts in excess of Allowable Amounts. See Calendar Year Out-of-Pocket Maximum for details. For Value Plus Plan participants, no one family member will have to pay more than $4,000 toward covered expenses in a single year.

<sup>4</sup> When receiving out-of-network services, you should call BCBSTX to preauthorize treatment before receiving care to avoid a reduction in benefits. See Preauthorization Requirements for more information.

<sup>5</sup> See What’s Covered for other important information.
### Traditional Medical Plan Summary Chart (continued)

<table>
<thead>
<tr>
<th>Other Covered Services</th>
<th>Traditional Plan</th>
<th>Out-of-Area Plan</th>
<th>Traditional Value Plus Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Diabetic Equipment, Supplies and Education</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>*Durable Medical Equipment</td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>*Obesity Treatment Limited to Medically Necessary treatment only.</td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>*Oral and Maxillofacial Treatment Medical treatment of the mouth, jaws and teeth.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>*Prosthetic Devices</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
<td>Payable in accordance with the type of expense incurred and the place where service is provided.</td>
</tr>
<tr>
<td>*Reconstructive or Cosmetic Surgery and Supplies</td>
<td>10%</td>
<td>10%</td>
<td>20%</td>
</tr>
</tbody>
</table>

1 For out-of-network benefits, you will pay your percentage of the cost based on the non-contracted Allowable Amount plus 100% of any excess amount above the non-contracted Allowable Amount (see Allowable Amounts).
2 See Calendar Year Deductible for information on what’s included and not included in the deductible.
3 Excludes certain expenses such as non-covered expenses, preauthorization penalties and amounts in excess of Allowable Amounts. See Calendar Year Out-of-Pocket Maximum for details. For Value Plus Plan participants, no one family member will have to pay more than $4,000 toward covered expenses in a single year.
4 When receiving out-of-network services, you should call BCBSTX to preauthorize treatment before receiving care to avoid a reduction in benefits. See Preauthorization Requirements for more information.
5 See What’s Covered for other important information.
Prescription Drug Summary Chart

The Plan includes coverage for prescription drugs for you and your eligible dependents regardless of the plan option you choose. You can purchase prescription drugs through a retail pharmacy (Participating or non-Participating) or through BCBSTX mail-order pharmacy, PrimeMail. The Plan does not cover all prescription drugs, medications and supplies. For full coverage details, refer to What's Covered under the Prescription Drug Benefit and Limitations and Exclusions for more information.

Highlights of the Prescription Drug Benefit

You are automatically enrolled if you participate in the Medical Plan. Benefits are available through retail pharmacies for short-term medications (up to a 30-day supply) or through PrimeMail for long-term maintenance medications (a 31- to 90-day supply). If you use a Participating retail pharmacy, you will pay less out-of-pocket than if you choose a non-Participating pharmacy.

<table>
<thead>
<tr>
<th></th>
<th>PPO Base Plan/Traditional Plan</th>
<th>Out-of-Area Plan</th>
<th>Value Plus Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Participating Pharmacy</td>
<td>Non-Participating Pharmacy</td>
<td>Participating Pharmacy</td>
</tr>
<tr>
<td><strong>Retail Pharmacy – Up to a 30-day Supply</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>20% coinsurance $10 minimum</td>
<td>50% of Allowable Amount</td>
<td>20% coinsurance $10 minimum</td>
</tr>
<tr>
<td>Preferred Brand Name Drugs</td>
<td>20% coinsurance $30 minimum</td>
<td>50% of Allowable Amount</td>
<td>20% coinsurance $30 minimum</td>
</tr>
<tr>
<td>Non-Preferred Brand Name Drugs</td>
<td>50% coinsurance</td>
<td>$60 minimum $250 maximum</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>Mail-Order Pharmacy – 31-day to 90-day Supply</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>20% coinsurance $20 minimum</td>
<td>N/A</td>
<td>20% coinsurance $20 minimum</td>
</tr>
<tr>
<td>Preferred Brand Name Drugs</td>
<td>20% coinsurance $60 minimum</td>
<td>N/A</td>
<td>20% coinsurance $60 minimum</td>
</tr>
<tr>
<td>Non-Preferred Brand Name Drugs</td>
<td>50% coinsurance</td>
<td>$120 minimum $500 maximum</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

* For non-Participating Pharmacies, you will pay your percentage of the cost based on the Allowable Amount for non-Participating Pharmacies, which is based on the Average Wholesale Price, plus any applicable copay.

** Under the Value Plus Plan option, participating and non-participating pharmacy expenses are subject to the calendar-year deductible and out-of-pocket maximum, except for covered preventive care drugs.

Certain Prescriptions May Require Prior Authorization or Step Therapy

Prior authorization and step therapy encourage safe, cost-effective medication use by allowing coverage when certain conditions are met. A team of physicians and pharmacists develops and approves the clinical programs and criteria for medications that are appropriate for these programs by reviewing U.S. Food and Drug Administration (FDA) approved labeling, scientific literature and nationally recognized guidelines. You can view which medications are designated for prior authorization or step therapy by viewing the plan formulary at bcbstx.com. If the formulary indicates you need prior authorization or step therapy (which may require the previous use of one or more medications before coverage for a specific drug is provided), your physician will need to submit a request form to BCBS for approval. Contact Member Services at (800) 521-2227 for assistance.

August 1, 2017
VALUE PLUS PLAN OPTIONS AND HEALTH SAVINGS ACCOUNTS

Participating in the Value Plus Plan gives you an opportunity to contribute to a Health Savings Account (HSA).

• An HSA is an interest-bearing savings account established exclusively to receive tax-favored contributions (much like an IRA) on behalf of eligible individuals and their spouses and dependents that are enrolled in a qualifying high deductible health plan like the Value Plus Plan.

• If you enroll in the Value Plus Plan, you will be eligible to receive contributions by Andeavor to your HSA. In addition, you can make pre-tax contributions to your HSA. For 2017:
  – Andeavor will contribute $500 for single coverage or $1,000 for family coverage (prorated over the Plan Year and made biweekly).
  – You may also make voluntary biweekly contributions on a pre-tax basis, provided the total amount of your contributions to your HSA for the year does not exceed the difference between Andeavor’s total contribution and the IRS maximums for the year. For 2017, the IRS maximums are $3,400 for single coverage and $6,750 for family coverage. If you will be age 55 or over during the year, you may make an additional catch-up contribution of $1,000.

• Amounts contributed to an HSA accumulate on a tax-free basis and are not subject to tax if they are used to pay for eligible medical expenses.

• Eligible medical expenses also include COBRA, Medicare and retiree group medical premiums.

• Contributions can be rolled over from year to year, which means contributions made in one year and not used to pay expenses in that year may be used to pay eligible medical expenses later.

To be eligible to participate in an HSA, you must:

• be enrolled in an eligible high deductible health plan like the Value Plus Plan;

• not be enrolled at the same time in a non-high deductible medical plan or receive impermissible coverage (e.g., receiving medical benefits prior to satisfaction of the annual deductible); and

• not be entitled to benefits under Medicare.

Note: Employees with family coverage resulting from covering domestic partners or the children of domestic partners will receive the Andeavor HSA contribution for single coverage.

IMPORTANT HEALTH SAVINGS ACCOUNT (HSA) INFORMATION

Andeavor does not sponsor or administer the HSA, and you do not have to contribute to the HSA to enroll in a Value Plus Plan. The Value Plus Plan is offered so you will be able to take advantage of the HSA and Andeavor’s contribution if you so desire (and meet the eligibility requirements). The Company will contribute to the HSA even if you do not. Note, however, that you must be enrolled in the Value Plus Plan to be eligible for Andeavor’s contribution to an HSA. The HSA is administered by Fidelity.

It is the responsibility of each HSA owner to ensure that he or she satisfies applicable HSA eligibility rules and complies with applicable contribution limitations. Contributions that are made by (or to) ineligible HSA owners and contributions in excess of IRS prescribed limits are taxable to the HSA owner and subject to an excise tax imposed on the HSA owner, unless distributed to the HSA owner within IRS-prescribed time frames. It is the HSA owner’s responsibility to request a distribution of excess contributions (including any Company contributions) within such time frames in order to avoid the excise tax.
BASIC PLAN PROVISIONS

Calendar Year Deductible

The calendar year deductible is the initial amount of eligible medical expenses you must pay before the Plan pays benefits. Deductibles apply to each calendar year and start over each January 1. The deductible does not include:

- copays;
- monthly premium contributions;
- costs for prescription drugs (except under the Value Plus Plan);
- out-of-network amounts exceeding the non-contracting Allowable Amount (see Allowable Amounts);
- expenses for services not covered under the Plan; or
- penalties for failure to preauthorize.

See the Standard Medical Plan Summary Chart or the Traditional Medical Plan Summary Chart to see the calendar year deductibles for each Medical Plan option.

Under All Options except the Value Plus Plan

There are two types of deductibles — individual deductibles and family deductibles — that work as follows:

- The individual deductible is the amount of your covered medical expenses you must first pay for each covered person before the Plan starts to pay benefits. Once a family member has met his or her individual deductible, the Plan will pay benefits for his or her covered expenses, regardless of whether other family members have incurred any covered expenses.
- Amounts applied to each covered person’s individual deductible are also applied to the family deductible. However, no one individual in the family will have to meet a deductible greater than his or her individual deductible.
- The family deductible is met when the accumulated expenses that were applied to each family member’s individual deductible equals or exceeds the family deductible amount.
- Once the family deductible has been met, all family members can begin receiving benefits for covered expenses without satisfying any additional deductible.

PPO BASE PLAN/TRADITIONAL PLAN — IN-NETWORK AND OUT-OF-NETWORK DEDUCTIBLES

If you are enrolled in this option, all covered medical expenses accumulate toward both the in-network deductible and out-of-network deductible. Once individual medical expenses equal the in-network deductible, the calendar year deductible will not apply to in-network expenses for the rest of the calendar year. Once the out-of-network deductible has been met, the in-network deductible will also be considered to have been met. The total deductible amount for the calendar year will not exceed the out-of-network deductible.

The calendar year deductible applies to all covered expenses except:

- physician fees for non-surgical office visits (Note: This exception applies only to in-network care);
- emergency room care;
- hospital facility expenses and inpatient physician services for a newborn child;
- Preventive care such as:
  - routine physical and well-child exams;
  - immunization expenses;
  - expenses for a routine pap smear, routine mammogram and routine screening for cancer of the prostate (including a digital rectal exam, PSA test, colonoscopy and sigmoidoscopy)
OUT-OF-AREA PLAN

The calendar year deductible applies to all covered expenses except:

• emergency room care;
• hospital facility expenses and inpatient physician services for a newborn child;
• Preventive care such as:
  – routine physical and well-child exams;
  – immunization expenses;
  – expenses for a routine pap smear, routine mammogram and routine screening for cancer of the prostate (including a digital rectal exam, PSA test, colonoscopy and sigmoidoscopy)

Under the Value Plus Plan Option

Instead of an individual and family deductible, the deductible under the Value Plus Plan is determined by the level in which you are enrolled (“Employee Only,” “Employee + Child(ren),” “Employee + Spouse” or “Employee + Family”) as follows:

• If you have “Employee Only” coverage under the Value Plus Plan, the Plan will pay benefits once you have reached the $1,500 calendar year deductible.
• For all other levels, the deductible is $3,000. There is no individual deductible, and the full family deductible of $3,000 must be met as a group (in total or by one individual) before any benefits (other than preventive care) will be paid for you or your dependents.

Under these options, all covered medical expenses accumulate toward both the in-network deductible and out-of-network deductible. Once individual medical expenses equal the in-network deductible, the calendar year deductible will not apply to in-network expenses for the rest of the calendar year. Once the out-of-network deductible has been met, the in-network deductible will also be considered to have been met. The total deductible amount for the calendar year will not exceed the out-of-network deductible.

The calendar year deductible applies to all expenses except:

• hospital facility expenses and inpatient physician services for a newborn child; and
• Preventive care such as:
  – routine physical and well-child exams;
  – immunization expenses;
  – expenses for a routine pap smear, routine mammogram and routine screening for cancer of the prostate (including a digital rectal exam, PSA test, colonoscopy and sigmoidoscopy)

Under the Value Plus Plan, the deductible must be generally met before the Plan begins paying benefits for retail or mail-order prescription drugs (except those drugs on the approved BCBSTX Preventive Drug List). Until the deductible is met, you will pay the full cost of any prescription drugs. The cost is discounted for prescriptions filled at network pharmacies.
Copayments

Copayments, or copays, are a fixed dollar amount you pay for certain services received under the PPO Base Plan and Traditional Plan options. The amount of your copay is determined by the option you select and the services you receive. See the Standard Medical Plan Summary Chart or the Traditional Medical Plan Summary Chart to see the copays for each applicable service.

COPAYS DO NOT APPLY TO:

- out-of-network benefits under the PPO Base/Traditional Plan;
- benefits under the Value Plus Plan; or
- benefits under the Out-of-Area Plan.

Coinsurance

After the annual deductible is met, if applicable, the Plan begins paying its percentage share of covered medical expenses for certain covered services, and you pay the rest. The percentage you pay is your “coinsurance.” The amount of coinsurance you pay is determined by the option you select. See the Standard Medical Plan Summary Chart or the Traditional Medical Plan Summary Chart to see the coinsurance for each applicable service.

Calendar Year Out-of-Pocket Maximum

The out-of-pocket maximum provision protects you from extreme financial loss in the event of catastrophic medical expenses. The out-of-pocket maximum limits the amount of covered expenses you must pay each year. The out-of-pocket maximums apply to each calendar year and start over each January 1. See the Standard Medical Plan Summary Chart or the Traditional Medical Plan Summary Chart to see the calendar year out-of-pocket maximums for each Medical Plan option.

The Plan will pay 100% of covered medical expenses for the remainder of the calendar year once the out-of-pocket maximum is reached.

The following out-of-pocket expenses do not apply to the out-of-pocket maximum and will not be paid at 100% even if you reach the maximum:

- monthly premium contributions;
- expenses for services not covered under the Plan;
- non-emergency use of the emergency room;
- out-of-network amounts exceeding non-contracting Allowable Amounts (see Allowable Amounts); and
- penalties for failure to preauthorize.

Under All Options Except the Value Plus Plan

There is an out-of-pocket maximum for each individual and for the entire family. Here is how the out-of-pocket maximum works:

- After a family member has paid costs for covered expenses (i.e. deductibles and coinsurance) in an amount equal to the individual out-of-pocket maximum, the Plan will pay 100% of any additional eligible medical expenses that family member incurs during the remainder of that calendar year, regardless of whether other family members have met their out-of-pocket maximums.
- Amounts applied to each individual’s out-of-pocket maximum are also applied to the family out-of-pocket maximum. However, no one individual in the family will have to meet an out-of-pocket maximum greater than his or her individual out-of-pocket maximum.
- The family out-of-pocket maximum is met when the accumulated expenses that were applied to each family member’s individual out-of-pocket maximum equals or exceeds the family out-of-pocket maximum amount.
• Once the family out-of-pocket maximum has been met, all individual out-of-pocket maximums are considered to be met for the calendar year.

**PPO BASE PLAN, TRADITIONAL PLAN AND VALUE PLUS PLAN OUT-OF-POCKET MAXIMUMS**

If you are enrolled in one of these options:

- covered medical expenses (except those excluded in the list) applied to the in-network out-of-pocket maximum will also be applied to satisfy the out-of-network out-of-pocket maximum; and
- covered medical expenses (except those excluded in the list) applied to the out-of-network out-of-pocket maximum will also be applied to satisfy the in-network out-of-pocket maximum.

Once you satisfy the in-network out-of-pocket maximum:

- any additional in-network expenses are covered at 100%; however
- you will not have been considered to have met the out-of-network out-of-pocket maximum. You would have to accumulate additional out-of-network expenses and satisfy the out-of-network maximum before out-of-network benefits would be paid at 100%.

**Under the Value Plus Plan Options**

Instead of an individual and family out-of-pocket maximum, the out-of-pocket maximum under the Value Plus Plan is determined by the level in which you are enrolled (“Employee Only,” “Employee + Child(ren),” “Employee + Spouse” or “Employee + Family”) as follows:

If you have “Employee Only” coverage under the Value Plus Plan, the Plan will pay 100% of covered medical expenses for the remainder of the calendar year once your $4,000 out-of-pocket maximum is reached.

For all other levels, the out-of-pocket maximum is $8,000. Once the full family out-of-pocket maximum of $8,000 is met, the Plan will pay 100% of covered medical expenses for all covered family members for the remainder of the calendar year. However, no one family member will have to pay more than $4,000 toward covered expenses in a single year.

**Allowable Amounts**

Allowable Amount means the maximum amount determined by the Claim Administrator (BCBSTX) to be eligible for consideration of payment for a particular covered service, supply or procedure.

When you choose to receive services, supplies or care from a provider that does not contract with BCBSTX (a non-contracting provider), you receive out-of-network Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount.

The non-contracting Allowable Amount will be the lesser of: (i) the provider’s billed charges or; (ii) the BCBSTX non-contracting Allowable Amount. The non-contracting Allowable Amount is developed from base Medicare participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor shall not be less than 300% and will exclude any Medicare adjustments which are based on information on the claim.

The non-contracted provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting provider’s billed charges. You will be responsible for this balance bill amount, which may be considerable. You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan, any applicable deductibles, coinsurance amounts and copays.
Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

The following types of services require preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient treatment of Mental Health Care,
- All inpatient treatment of Serious Mental Illness,
- All inpatient treatment of Chemical Dependency, and
- If you transfer to another facility or to or from a specialty unit within the facility.
- The following outpatient treatment of Mental Health Care, Serious Mental Illness and Chemical Dependency:
  - Psychological testing,
  - Neuropsychological testing,
  - Electroconvulsive therapy, and
  - Intensive Outpatient Program.

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

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

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

However, if care is not available from Network Providers as determined by the Claim Administrator, and the Claim Administrator authorizes your visit to an Out-of-Network Provider prior to the visit, In-Network Benefits will be paid; otherwise, Out-of Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

You are responsible for satisfying Preauthorization requirements. This means that you must ensure that you, your family member, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in **Failure to Preauthorize.**
To receive authorization to use Out-of-Network Providers when services are not available from Network Providers, call the Medical Preauthorization Helpline at (800) 441-9188 prior to using the Out-of-Network services.

**Failure to Preauthorize**

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the outpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency is not obtained:

- BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.
- You may be responsible for a penalty in connection with the following Covered Services:
  - Inpatient Hospital Admission
  - Inpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency

The penalty charge will be deducted from any benefit payment which may be due for Covered Services. If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency or extension for any treatment or service described above is not preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or was Experimental/Investigational, benefits will be reduced or denied.

**Preauthorization for Maternity Care or Treatment of Breast Cancer**

Preauthorization is not necessary for the following minimum-lengths-of-stay:

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

If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining preauthorization from BCBSTX.
Mental Health and Substance Abuse Treatment

Treatment of mental health and substance abuse is covered the same as any other medical expense. Only treatment that is determined to be a covered health service will be covered under the Plan. See What's Covered for details on the mental health and substance abuse copays and coinsurance for each option.

Out-of-Network Mental Health and Substance Abuse Benefits

If you are in a medical option that offers a choice between in-network and out-of-network and you choose to use an out-of-network provider, the benefits paid by the Plan will be substantially lower.

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

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

All inpatient and certain outpatient care for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be Preauthorized by calling the toll-free Mental Health Helpline indicated on your Identification Card.

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency

In the case of an elective inpatient Hospital Admission, the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In order to receive maximum benefits, all inpatient treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency must be Preauthorized by the Plan.

An emergency is any situation in which failure to get immediate care may result in serious harm or danger to you, to the patient or to others.

Preauthorization is also required for certain outpatient services. Outpatient services requiring Preauthorization include psychological testing, neuropsychological testing, Intensive Outpatient Programs and electroconvulsive therapy.

Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

To satisfy Preauthorization requirements, you, a family member or your Behavioral Health Practitioner must call the Mental Health/Chemical Dependency preauthorization Helpline toll-free number shown on your Identification Card.

The Mental Health/Chemical Dependency Preauthorization Helpline is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

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

The Company offers an Employee Assistance Program, Deer Oaks, that is a comprehensive resource available to help you face life's everyday challenges. Through Deer Oaks, you have access to a free and confidential service that offers help with personal and work-related issues for employees and their families. You can find the Deer Oaks brochure on HR Connect at tsocorp.com/hrconnect for more information.
Important Plan Features

Blue Distinction® Centers

If you have specialty care needs, such as transplants or spinal surgery, Blue Distinction® can help you find the right hospital or health care facility. Blue Distinction recognizes medical facilities that deliver better overall care for high-volume, high-risk and high-cost areas of specialty care, including:

- Blue Distinction Centers for Bariatric Surgery®
- Blue Distinction Centers for Cardiac Care®
- Blue Distinction Centers for Transplants®
- Blue Distinction Centers for Complex and Rare Cancers®
- Blue Distinction Centers for Knee and Hip Replacement™
- Blue Distinction Centers for Spine Surgery™

Blue Distinction Centers can be found online at Blue Access for Members™ or by calling a Benefit Value Advisor. For more information about covered services for transplants and other specialty care, see What’s Covered.

Benefits Value Advisors

BCBSTX Benefits Value Advisors are available to help you understand your medical benefits and assist you with your health care needs. Call the Member Services number on the back of your BCBSTX ID card to:

- Find in-network providers or facilities
- Find Blue Distinction Centers for specialty care
- Get a cost estimate for health care services
- Schedule a doctor or procedure appointment
- Get information about a medical condition
- Arrange a preauthorization
- Learn about additional resources

Blue365® Member Discount Programs

From time to time, discount arrangements or special rates from certain service providers, such as pharmacies, optometrists, dentists, alternative medicine, wellness and healthy living providers may be offered under the Plan. These arrangements may be modified or discontinued at any time.

Some of these arrangements may be offered by third parties who may make payments to BCBSTX in exchange for making these services available. These third party providers are independent contractors and are solely responsible to you for any goods and/or services provided. These discount arrangements are not insurance and no benefits are payable to you or the providers for any services they may render through discount arrangements.
WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

| Inpatient Hospital Expenses | The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Preauthorization. The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under “Inpatient Hospital Expenses” in the BCBSTX plan document is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay. This excess amount will be applied to the Co-Share Amounts. Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided the Claim Administrator acknowledges your visit to an Out-of-Network Provider prior to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate. For Out-of-Area services and supplies, the benefit percentage of your total eligible Inpatient Hospital Expense in excess of any Deductible indicated in your BCBSTX plan document is the Plan’s obligation. The remaining unpaid Inpatient Hospital Expense in excess of any Deductible is your obligation to pay. This excess amount will be applied to the Co-Share Amounts. |
| Medical-Surgical Expenses | The Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Preauthorization. Copayment Amounts must be paid to your Network Physician or other Network Providers at the time you receive services. The benefit percentages of your total eligible Medical-Surgical Expense shown under “Medical-Surgical Expenses” in your BCBSTX plan document in excess of your Copayment Amounts, Co-Share Amounts, and any applicable Deductibles shown are the Plan's obligation. The remaining unpaid Medical-Surgical Expense in excess of the Copayment Amounts, Co-Share Amounts, and any Deductibles is your obligation to pay. Medical-Surgical Expense shall include: • Services of Physicians and Professional Other Providers. • Consultation services of a Physician and Professional Other Provider. • Services of a certified registered nurse-anesthetist (CRNA). • Diagnostic x-ray and laboratory procedures. • Radiation therapy. • Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term “durable medical equipment (DME)” shall not include: – Equipment primarily designed for alleviation of pain or provision of patient comfort; or – Home air fluidized bed therapy. • Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment. • Professional local ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant’s condition. • Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider. • Oxygen and its administration provided the oxygen is actually used. • Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant. • Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant. • Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any
WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

<table>
<thead>
<tr>
<th>Medical-Surgical Expenses (continued)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-</td>
<td>prescribed, directed, or applied dressings, bandages, trusses,</td>
</tr>
<tr>
<td>prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed</td>
<td>for the purpose of assisting the function of a joint.</td>
</tr>
<tr>
<td>for the purpose of assisting the function of a joint.</td>
<td></td>
</tr>
<tr>
<td>• Home Infusion Therapy.</td>
<td></td>
</tr>
<tr>
<td>• Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic</td>
<td>Center, or a Chemical Dependency Treatment Center, or scheduled</td>
</tr>
<tr>
<td>Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient</td>
<td>treatment room of a Hospital.</td>
</tr>
<tr>
<td>treatment room of a Hospital.</td>
<td></td>
</tr>
<tr>
<td>• Certain Diagnostic Procedures.</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Contraceptive Services. NOTE: Prescription contraceptive medications are covered under</td>
<td>the Prescription Drug Benefit portion of your Plan.</td>
</tr>
<tr>
<td>the Prescription Drug Benefit portion of your Plan.</td>
<td></td>
</tr>
<tr>
<td>• Telehealth Services and Telemedicine Medical Services.</td>
<td></td>
</tr>
<tr>
<td>• Foot care in connection with an illness, disease, or condition, such as but not limited to</td>
<td>peripheral neuropathy, chronic venous insufficiency, and</td>
</tr>
<tr>
<td>peripheral neuropathy, chronic venous insufficiency, and diabetes.</td>
<td></td>
</tr>
<tr>
<td>• Drugs that have not been approved by the FDA for self-administration when injected, ingested or</td>
<td>applied in a Physician’s or Professional Other Provider’s office.</td>
</tr>
<tr>
<td>applied in a Physician’s or Professional Other Provider’s office.</td>
<td></td>
</tr>
<tr>
<td>• Elective Sterilizations.</td>
<td></td>
</tr>
<tr>
<td>• Acupuncture, up to the maximum visits shown in the BCBSTX Schedule of Coverage.</td>
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</tr>
</tbody>
</table>

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require Preauthorization.

The Plan’s benefit obligation as shown in your BCBSTX plan document will be:

• At the benefit percentage under “Extended Care Expenses,” and

• Up to the number of days or visits shown for each category of Extended Care Expenses in the BCBSTX Schedule of Coverage.

All payments made by the Plan, whether under the In-Network, Out-of-Network or Out-of-Area Benefit level, will apply toward the benefit maximums. Out-of-Area benefits are not available unless services are rendered by a Contracting Facility and have been Preauthorized and approved by the Claim Administrator.

The benefit maximums will also include any benefits provided to a Participant for Extended Care Expenses under a Health Benefit Plan held by the Employer with the Claim Administrator immediately prior to the Participant’s Effective Date of coverage under the Plan.

If shown in your BCBSTX plan document, the Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown in your BCBSTX plan document will not be applied to any Co-Share Stop-Loss Amount. Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical-Surgical Expenses.

Services and supplies for Extended Care Expenses:

• For Skilled Nursing Facility:
  – All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
  – Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
  – Physical, occupational, speech, and respiratory therapy services by licensed therapists.
WHAT'S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

<table>
<thead>
<tr>
<th>Extended Care Expenses (continued)</th>
<th>For Home Health Care:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);</td>
</tr>
<tr>
<td></td>
<td>Part-time or intermittent home health aide services which consist primarily of caring for the patient;</td>
</tr>
<tr>
<td></td>
<td>Physical, occupational, speech, and respiratory therapy services by licensed therapists;</td>
</tr>
<tr>
<td></td>
<td>Supplies and equipment routinely provided by the Home Health Agency.</td>
</tr>
<tr>
<td>Benefits will not be provided for Home Health Care for the following:</td>
<td>Food or home delivered meals;</td>
</tr>
<tr>
<td></td>
<td>Social case work or homemaker services;</td>
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<tr>
<td></td>
<td>Services provided primarily for Custodial Care;</td>
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<tr>
<td></td>
<td>Transportation services;</td>
</tr>
<tr>
<td></td>
<td>Home Infusion Therapy;</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment.</td>
</tr>
<tr>
<td>For Private Duty Nursing</td>
<td>For Hospice Care:</td>
</tr>
<tr>
<td>Home Hospice Care:</td>
<td>Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or</td>
</tr>
<tr>
<td></td>
<td>by a Licensed Vocational Nurse (L.V.N.);</td>
</tr>
<tr>
<td></td>
<td>Part-time or intermittent home health aide services which consist primarily of caring for the patient;</td>
</tr>
<tr>
<td></td>
<td>Physical, speech, and respiratory therapy services by licensed therapists;</td>
</tr>
<tr>
<td></td>
<td>Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.</td>
</tr>
<tr>
<td>Facility Hospice Care:</td>
<td>All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);</td>
</tr>
<tr>
<td></td>
<td>Room and board and all routine services, supplies, and equipment provided by the Hospice facility;</td>
</tr>
<tr>
<td></td>
<td>Physical, speech, and respiratory therapy services by licensed therapists.</td>
</tr>
</tbody>
</table>

Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.
### WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

| Maternity Care | Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for Maternity Care benefits. Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan. The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:
| | • 48 hours following an uncomplicated vaginal delivery; and |
| | • 96 hours following an uncomplicated delivery by caesarean section. |
| | If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for Postdelivery Care for the mother and newborn. The Postdelivery Care may be provided at the mother’s home, a health care Provider’s office, or a health care facility. Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:
| | • parent education, |
| | • assistance and training in breast-feeding and bottle feeding, and |
| | • the performance of any necessary and appropriate clinical tests. |
| | Charges for well-baby nursery care, including the initial examination, of a newborn child during the mother’s Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions as described under Inpatient Hospital Expenses. Benefits will also be subject to any Deductible amounts shown in the BCBSTX Schedule of Coverage. |
| Emergency Care and Treatment of Accidental Injury | The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are:
| | • unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult |
| | • breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings. |
| | If reasonably possible, contact your Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network. Whether you require hospitalization or not, you should notify your Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services. Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown in your BCBSTX plan document. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room/treatment room visit as indicated in the BCBSTX Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived and Preauthorization of the inpatient Hospital Admission will be required. All treatment received following the onset of an accidental injury or emergency care will be eligible for In-Network Benefits. For a non-emergency, In-Network Benefits will be available only if you use Network Providers. For a non-emergency, if you can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available. |
WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

<table>
<thead>
<tr>
<th>Emergency Care and Treatment of Accidental Injury (continued)</th>
<th>Notwithstanding anything in the Plan Document to the contrary, for Out-of-Network Emergency Care services rendered by non-contracting Providers, the non-contracting Allowable Amount shall be equal to the greatest of the following three possible amounts—not to exceed billed charges:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>• the median amount negotiated with In-Network Providers for Emergency Care services furnished;</td>
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<tr>
<td></td>
<td>• the amount for the Emergency Care service calculated using the same method the Plan generally uses to determine payments for Out-of-Network services but substituting the In-Network cost-sharing provisions for the Out-of-Network cost sharing provisions; or</td>
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<tr>
<td></td>
<td>• the amount that would be paid under Medicare for the Emergency Care service.</td>
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<tr>
<td>Each of these three amounts is calculated excluding any In-Network Copayment Amount or Co-Share Amount imposed with respect to the Participant.</td>
<td></td>
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</tbody>
</table>

| Urgent Care or Retail Health Clinic | Benefits for Eligible Expenses for Urgent Care or a Retail Health Clinic will be determined as shown in the BCBSTX plan document. A Copayment Amount, in the amount indicated the BCBSTX Schedule of Coverage, will be required for each Urgent Care or Retail Health Clinic visit. Urgent Care or Retail Health Clinic means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a hospital emergency room/treatment room department or physician’s office. The necessary medical care is for a condition that is not life-threatening. |

| Speech and Hearing Services | Benefits as shown in your BCBSTX Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function. |

<table>
<thead>
<tr>
<th>Developmental Delays</th>
<th>Developmental Delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Cognitive development;</td>
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<td></td>
<td>• Physical development;</td>
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<td></td>
<td>• Communication development;</td>
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<td></td>
<td>• Social or emotional development; or</td>
</tr>
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<td></td>
<td>• Adaptive development.</td>
</tr>
<tr>
<td>Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan, which means an initial and ongoing treatment plan. Such therapies include:</td>
<td></td>
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<td></td>
<td>• occupational therapy evaluations and services;</td>
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<tr>
<td></td>
<td>• physical therapy evaluations and services;</td>
</tr>
<tr>
<td></td>
<td>• speech therapy evaluations and services; and</td>
</tr>
<tr>
<td></td>
<td>• dietary or nutritional evaluations.</td>
</tr>
<tr>
<td>The Individualized Family Service Plan must be submitted to the Claim Administrator prior to the commencement of services and when the Individualized Family Service Plan is altered. Once the child reaches the age of three, when services under the Individualized Family Service Plan are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Screening Tests for Hearing Impairment</th>
<th>Benefits are available for Eligible Expenses incurred by a covered Dependent child:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• For a screening test for hearing loss from birth through the date the child is 30 days old; and</td>
</tr>
<tr>
<td></td>
<td>• Necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.</td>
</tr>
</tbody>
</table>
**WHAT’S COVERED – MEDICAL COVERAGE DETAILS**

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

| Cosmetic, Reconstructive, or Plastic Surgery | The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your BCBSTX Schedule of Coverage:
|                                                                                      | • Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
|                                                                                      | • Treatment provided for reconstructive surgery following cancer surgery; or
|                                                                                      | • Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
|                                                                                      | • Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
|                                                                                      | • Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
|                                                                                      | • Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. |
| Dental Services                                                                 | Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown in your BCBSTX Schedule of Coverage only for the following:
|                                                                                      | • Covered Oral Surgery;
|                                                                                      | • Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
|                                                                                      | • The correction of damage caused solely by external, violent Accidental Injury to healthy, unrestored natural teeth and supporting tissues and limited to treatment provided within 24 months of the Accidental Injury. An injury sustained as a result of biting or chewing, or as the result of receiving other medical treatment (e.g. chemotherapy) shall not be considered an Accidental Injury. |
| Organ and Tissue Transplants                                                         | Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:
|                                                                                      | • The transplant procedure is not Experimental/Investigational in nature; and
|                                                                                      | • Donated human organs or tissue or an FDA-approved artificial device are used; and
|                                                                                      | • The recipient is a Participant under the Plan; and
|                                                                                      | • The transplant procedure is Preauthorized as required under the Plan; and
|                                                                                      | • The Participant meets all of the criteria established by the Claim Administrator in pertinent written medical policies; and
|                                                                                      | • The Participant meets all of the protocols established by the Hospital in which the transplant is performed.
|                                                                                      | Covered services and supplies “related to” an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant. |
|                                                                                      | Benefits are available and will be determined on the same basis as any other sickness when the }
WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

<table>
<thead>
<tr>
<th>Organ and Tissue Transplants (continued)</th>
<th>transplant procedure is considered Medically Necessary and meets all of the conditions cited above. Benefits will be available for:</th>
</tr>
</thead>
</table>
|                                         | • A recipient who is covered under this Plan; and  
|                                         | • A donor who is a Participant under this Plan.  
| Covered services and supplies include services and supplies provided for the: |  
|                                         | • Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and  
|                                         | • Donor search and acceptability testing of potential live donors; and  
|                                         | • Removal of organs or tissues from living or deceased donors; and  
|                                         | • Transportation and short-term storage of donated organs or tissues; and  
|                                         | • Living and/or travel expenses of the recipient or a live donor.  
| No benefits are available for a Participant for the following services or supplies: |  
|                                         | • Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;  
|                                         | • Purchase of the organ or tissue; or  
|                                         | • Organs or tissue (xenograft) obtained from another species.  
| Preauthorization is required for any organ or tissue transplant. Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization. |  
|                                         | • At the time of Preauthorization, the Claim Administrator will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if the Claim Administrator determines that an extension is Medically Necessary.  
| No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which the Claim Administrator considers to be Experimental/Investigational. |  

<table>
<thead>
<tr>
<th>Acquired Brain Injury</th>
<th>Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an Acquired Brain Injury:</th>
</tr>
</thead>
</table>
|                       | • Cognitive communication therapy - Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;  
|                       | • Cognitive rehabilitation therapy - Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual’s brain-behavioral deficits;  
|                       | • Community reintegration services - Services that facilitate the continuum of care as an affected individual transitions into the community;  
|                       | • Neurobehavioral testing - An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;  
|                       | • Neurobehavioral treatment - Interventions that focus on behavior and the variables that control behavior;  
|                       | • Neuropsychological rehabilitation - Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing |
WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

### Acquired Brain Injury (continued)
- Remediation - The process(es) of restoring or improving a specific function.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury. Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

### Diabetes
Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for Diabetes Equipment and Diabetes Supplies (for which a Physician or Professional Other Provider has written an order) and Diabetic Management Services/Diabetes Self-Management Training. Such items, when obtained for a Qualified Participant, shall include but not be limited to the following:
- Diabetes Equipment
  - Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
  - Insulin pumps (both external and implantable) and associated appurtenances, which include:
    - Insulin infusion devices,
    - Batteries,
    - Skin preparation items,
    - Adhesive supplies,
    - Infusion sets,
    - Insulin cartridges,
    - Durable and disposable devices to assist in the injection of insulin, and
    - Other required disposable supplies; and
  - Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.
WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

<table>
<thead>
<tr>
<th>Diabetes (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Diabetes Supplies</td>
</tr>
<tr>
<td>- Test strips specified for use with a corresponding blood glucose monitor,</td>
</tr>
<tr>
<td>- Visual reading and urine test strips and tablets for glucose, ketones, and protein,</td>
</tr>
<tr>
<td>- Lancets and lancet devices,</td>
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<tr>
<td>- Insulin and insulin analog preparations,</td>
</tr>
<tr>
<td>- Injection aids, including devices used to assist with insulin injection and needleless systems,</td>
</tr>
<tr>
<td>- Biohazard disposable containers,</td>
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<tr>
<td>- Insulin syringes,</td>
</tr>
<tr>
<td>- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and</td>
</tr>
<tr>
<td>- Glucagon emergency kits.</td>
</tr>
<tr>
<td>NOTE: All Diabetes Supplies listed above will be covered under the Prescription Drug Benefit portion of your plan.</td>
</tr>
<tr>
<td>• Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer’s warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.</td>
</tr>
<tr>
<td>• As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.</td>
</tr>
<tr>
<td>• Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the Qualified Participant. Such Diabetic Management Services/Diabetes Self-Management Training for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician. Initial and follow-up instruction concerning:</td>
</tr>
<tr>
<td>- The physical cause and process of diabetes;</td>
</tr>
<tr>
<td>- Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;</td>
</tr>
<tr>
<td>- Prevention and treatment of special health problems for the diabetic patient;</td>
</tr>
<tr>
<td>- Adjustment to lifestyle modifications; and</td>
</tr>
<tr>
<td>- Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.</td>
</tr>
</tbody>
</table>

Diabetes Self-Management Training for the Qualified Participant will include the development of an individualized management plan that is created for and in collaboration with the Qualified Participant (and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Diabetes Supplies.

A Qualified Participant means an individual eligible for coverage under this Plan who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

<table>
<thead>
<tr>
<th>Physical Medicine Services</th>
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</thead>
<tbody>
<tr>
<td>Benefits for Medical-Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your BCBSTX Schedule of Coverage.</td>
</tr>
</tbody>
</table>
### What’s Covered – Medical Coverage Details

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available as shown on your BCBSTX Schedule of Coverage. However, Chiropractic Services benefits for all visits during which physical treatment is rendered, whether under the In-Network, Out-of-Network, or Out-of-Area Benefits level, will not be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your BCBSTX Schedule of Coverage. Any visits during which no physical treatment is rendered will not count toward the visit maximum.</td>
</tr>
</tbody>
</table>
| **Routine Patient Costs for Participants in Certain Clinical Trials** | Benefits for Eligible Expenses for Routine Patient Care Costs, are provided in connection with a phase I, phase II, phase III, or Phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:
  - the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
  - the National Institutes of Health (NIH);
  - Centers for Medicare and Medicaid Services;
  - Agency for Healthcare Research and Quality;
  - A cooperative group or center of any of the previous entities;
  - the United States Food and Drug Administration;
  - the United States Department of Defense (DOD);
  - the United States Department of Veterans Affairs (VA);
  - a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or
  - an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protection of the United States Department of Health and Human Services. Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial. |
| **Routine Patient Costs for Participants in Certain Clinical Trials (continued)** | Preventive Care Services will be provided for the following covered services:
  - evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
  - immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
  - evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
  - with respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA. For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009). The Preventive Care Services listed above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on your Identification Card. Examples of covered services included are routine annual physicals; immunizations; well-child care; breastfeeding support, services and supplies; cancer screening mammograms; bone density test; screening for prostate cancer and colorectal cancer; smoking cessation counseling services; healthy diet...
WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

| Preventive Care Services (continued) | counseling; and obesity screening/counseling. Examples of covered immunizations included are Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision. Examples of covered services for women with reproductive capacity are female sterilization procedures and Outpatient Contraceptive Services; FDA-approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner; and specified FDA-approved contraception methods with a written prescription by a Health Care Practitioner provided in the Prescription Drug Benefit from the following categories: progestin-only contraceptives, combination contraceptives, emergency contraceptives, extended cycle/continuous oral contraceptives, cervical caps, diaphragms, implantable contraceptives, intra-uterine devices, injectables, transdermal contraceptives and vaginal contraceptive devices. To determine if a specific contraceptive drug or device is included in this benefit, refer to the Women’s Preventive Health Services - Contraceptive Information page located on the website at www.bcbstx.com/affordable_care_act/provisions.html or contact Customer Service at the toll-free number on your Identification Card. The list may change as FDA guidelines are modified. Benefits are not available under this benefit provision for contraceptive drugs and devices not listed on the Women’s Preventive Health Services - Contraceptive Information page. You may, however, have coverage under other sections of the BCBSTX Plan Document, subject to any applicable Co-Share Amounts, Deductibles, Copayment Amounts and/or benefit maximums. Preventive Care Services provided by an non-Participating Pharmacy for the items above and/or the Women’s Preventive Health Services - Contraceptive Information List will be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or applicable dollar maximums. Covered services not included in items above and/or the Women’s Preventive Health Services - Contraceptive Information List will be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or applicable dollar maximums. |
| Breastfeeding Support, Services and Supplies | Benefits will be provided for breastfeeding counseling and support services by a Professional Other Provider during pregnancy and/or in the postpartum period as shown in Preventive Care Services on your BCBSTX Schedule of Coverage. Benefits provided by a Network Provider will not be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or dollar maximums. Benefits will also be provided for the rental (but not to exceed the total cost) or purchase of (1) a manual breast pump, or (2) electric breast pump when supplied by an In-Network Provider or contracted Durable Medical Equipment (DME) supplier; including accessories and supplies as shown in Preventive Care Services on your BCBSTX Schedule of Coverage. The Participant will be responsible for submitting a claim form and the itemized receipt for the rental or purchase of the manual or electric breast pump, accessories and supplies. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form. |
| Mammography Screening | Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant, as shown in Preventive Care Services on your BCBSTX Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year. |
## WHAT'S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

| Detection and Prevention of Osteoporosis | If a Participant is a Qualified Individual, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant’s risk of osteoporosis and fractures associated with osteoporosis, as shown in Preventive Care Services on your BCBSTX Schedule of Coverage. Qualified Individual means: 1. A postmenopausal woman not receiving estrogen replacement therapy; 2. An individual with:  • vertebral abnormalities,  • primary hyperparathyroidism, or  • a history of bone fractures; or 3. An individual who is:  • receiving long-term glucocorticoid therapy, or  • being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy. |
| Detection of Colorectal Cancer | Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer, include:  • A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or  • A colonoscopy performed every ten years. Benefits will be provided for Physician Services, as shown in Preventive Care Services on your BCBSTX Schedule of Coverage. |
| Detection of Human Papillomavirus and Cervical Cancer | Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is 18 years of age or older, for an annual medically recognized diagnostic examination for the early detection of cervical cancer, as shown in Preventive Care Services on your BCBSTX Schedule of Coverage. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus. |
| Detection of Prostate Cancer | Benefits are available, as shown in Preventive Care Services on your BCBSTX Schedule of Coverage, for an annual medically recognized diagnostic physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:  • 50 years of age and asymptomatic; or  • 40 years of age with a family history of prostate cancer or another prostate cancer risk factor. |
## WHAT’S COVERED – MEDICAL COVERAGE DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Medical Plan Summary Charts to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Description</th>
</tr>
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</table>
| **Childhood Immunizations**             | Benefits for Medical-Surgical Expenses incurred by a Dependent child for childhood immunizations will be determined at 100% of the Allowable Amount. Deductibles, Copayment Amounts, and Co-Share Amounts will not be applicable, as shown in Preventive Care Services on your BCBSTX Schedule of Coverage. Benefits are available for:  
  - Diphtheria,  
  - Hemophilus influenza type b,  
  - Hepatitis B,  
  - Measles,  
  - Mumps,  
  - Pertussis,  
  - Polio,  
  - Rubella,  
  - Tetanus,  
  - Varicella, and  
  - Any other immunization that is required by law for the child.  
  Injections for allergies are not considered immunizations under this benefit provision. |
| **Morbid Obesity**                      | Benefits for Eligible Expenses incurred by a Participant for the Medically Necessary treatment of Morbid Obesity will be provided on the same basis as for any other sickness. Benefits are available for healthy diet counseling and obesity screening/counseling as shown in Preventive Care Services on your BCBSTX Schedule of Coverage. |
| **Benefits for Other Routine Services** | Benefits for other routine services are available for the following as indicated on your BCBSTX Schedule of Coverage:  
  - x-rays; and  
  - annual hearing examinations, except for benefits as provided under Benefits for Screening Tests for Hearing Impairment. |
| **Mental Health Care, Treatment of Serious Mental Illness and Treatment of Chemical Dependency** | Benefits for Eligible Expenses incurred for Mental Health Care, treatment of Serious Mental Illness and treatment of Chemical Dependency will be the same as for treatment of any other sickness. Refer to Preauthorization Requirements to determine what services require Preauthorization.  
Any Eligible Expenses incurred for the services of a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents for Medically Necessary Mental Health Care or treatment of Serious Mental Illness in lieu of inpatient hospital services will, for the purpose of this benefit, be considered Inpatient Hospital Expenses.  
Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. However, treatment in a Hospital for the medical management of acute life-threatening intoxication (toxicity) will be an exception to this provision. |
MEDICAL LIMITATIONS AND EXCLUSIONS

What Is NOT Covered Under the Plan

Not every medical service or supply is covered by the Plan, even if prescribed, recommended or approved by your physician or dentist or if it is the only available treatment for your condition. The Plan covers only those services and supplies that are medically necessary and included under What's Covered. Charges made for the following are not covered except to the extent listed under these sections.

The Plan will not pay medical benefits for any of the services, treatments, items or supplies described in this section as determined by the Claims Administrator in its sole discretion. This list of benefit exclusions is not all-inclusive. If you have a question on a specific expense, contact the Claims Administrator.

The exclusions listed below apply to all coverage under your Plan. Additional exclusions apply to specific prescription drug coverage and are listed separately under Prescription Drug Benefit Limitations and Exclusions.

• Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
• Any Experimental/Investigational services and supplies.
• Any portion of a charge for a service or supply that is in excess of the contracting Allowable Amount (or, if applicable, the non-contracting Allowable Amount) as determined by the Claim Administrator.
• Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
• Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
• Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or mental retardation provided by a tax supported institution of the State of Texas.
• Any services or supplies provided by a person who is related to the Participant by blood or marriage.
• Any services or supplies provided for injuries sustained:
  – As a result of war, declared or undeclared, or any act of war; or
  – While on active or reserve duty in the armed forces of any country or international authority.
• Any charges:
  – Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
  – For completion of any insurance forms; or
  – For acquisition of medical records.
• Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.
• Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage, unless coverage is continued under Continuation of Coverage Under COBRA.
• Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
  – Preventive Care Services as shown on your BCBSTX Schedule of Coverage; or
  – an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claim Administrator; or
  – Benefits for Treatment of Diabetes as described in What’s Covered; or
  – Benefits for Certain Therapies for Children with Developmental Delays as described in What’s Covered.
• Any services or supplies provided for Custodial Care.
• Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.
• Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the Benefits for Dental Services provision in the What’s Covered section.
• Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the Benefits for Cosmetic, Reconstructive, or Plastic Surgery provision in the Special Provisions Expenses portion of the BCBSTX Plan Document.
• Any services or supplies provided for:
  – Treatment of myopia and other errors of refraction, including refractive surgery; or
  – Orthoptics or visual training; or
  – Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
  – Examinations for the prescription or fitting of eyeglasses or contact lenses; or
  – Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the Benefits for Speech and Hearing Services provision in the Special Provisions Expenses portion of the BCBSTX Plan Document.
• Except as specifically included as an Eligible Expense, any Medical Social Services, any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or marriage counseling.
• Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.
• Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the Benefits for Physical Medicine Services provision in the Special Provisions Expenses portion of the BCBSTX Plan Document.
• Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.
• Any services or supplies provided primarily for:
  – Environmental Sensitivity;
  – Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
  – Inpatient allergy testing or treatment.
• Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
• Any services or supplies provided for, in preparation for, or in conjunction with:
  – Sterilization reversal (male or female);
  – Sexual dysfunctions;
  – In vitro fertilization; and
  – Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial 
    insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal 
    insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, 
    zygote intra-fallopian transfer, and tubal embryo transfer.

• Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the 
  cutting and trimming of toenails in the absence of severe systemic disease.

• Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.

• Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, except as 
  required by the Affordable Care Act for dependent children under age 6.

• Any services or supplies provided for the following treatment modalities:
  – intersegmental traction;
  – surface EMGs;
  – spinal manipulation under anesthesia; and
  – muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

• Any services or supplies furnished under the In-Network or Out-of-Network portions of the Plan by a Contracting 
  Facility for which such facility had not been specifically approved to furnish under a written contract or agreement with 
  the Claim Administrator will be paid at the Out-of-Network benefit level.

• Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided 
  by a Physician in a non-hospital setting or purchased “over the counter” for support of strains and sprains; orthopedic 
  shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, 
  shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic 
  stockings and garter belts. NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic 
  Equipment.

• Any benefits in excess of any specified dollar, day/visit, or Calendar Year maximums.

• Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the 
  location for the purposes of receiving medical services, supplies, or drugs.

• Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under 
  this Plan.

• Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.

• Any Covered Drugs for which benefits are available under the Prescription Drug Benefit portion of the Plan.

• Any outpatient prescription or nonprescription drugs.

• Any non-prescription contraceptive medications or devices for male use.

• Any services or supplies provided for reduction mammoplasty.

• Any non-surgical services or supplies provided for reduction of obesity or weight, even if the Participant has other 
  health conditions which might be helped by a reduction of obesity or weight.

• Biofeedback (except for an Acquired Brain Injury diagnosis) or other behavior modification services.
• Any related services to a non-covered service. Related services are:
  – services in preparation for the non-covered service;
  – services in connection with providing the non-covered service;
  – hospitalization required to perform the non-covered service; or
  – services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
• Any services or supplies for elective abortions.
• Any services or supplies not specifically defined as Eligible Expenses in this Plan.
• Unauthorized services, including any service obtained by or on behalf of a covered person without preauthorization by the Claims Administrator when required. This exclusion does not apply in a medical emergency or in an urgent care or retail health clinic situation.

Preexisting Conditions

The Plan does not exclude benefit coverage based on any preexisting conditions. When you and your covered dependents enroll in the Plan, you are immediately eligible for all covered benefits even if you have a preexisting condition at the time you enroll.
PRESCRIPTION DRUG BENEFIT

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

1. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Is recognized by the following for treatment of the indication for which the drug is prescribed
   a. a prescription drug reference compendium, approved by the appropriate state agency, or
   b. substantially accepted peer-reviewed medical literature.

As new drugs are approved by the FDA, such drugs, unless the intended use is specifically excluded under the Plan, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names. In such cases, BCBSTX may limit benefits to only one of the brand equivalents available. Benefits are available for Covered Drugs as indicated on in the chart, which gives benefit descriptions, explanations and limitations for covered prescription drug benefits.

Participating Pharmacy

The Plan provides access to covered benefits through a network of BCBSTX pharmacies, vendors and suppliers. Participating pharmacies include retail, mail-order and specialty pharmacies. When you fill your prescription at participating retail pharmacy, you will pay less than if you use a non-participating pharmacy.

Certain Prescriptions May Require Prior Authorization or Step Therapy

Prior authorization and step therapy encourage safe, cost-effective medication use by allowing coverage when certain conditions are met. A team of physicians and pharmacists develops and approves the clinical programs and criteria for medications that are appropriate for these programs by reviewing U.S. Food and Drug Administration (FDA) approved labeling, scientific literature and nationally recognized guidelines. You can view which medications are designated for prior authorization or step therapy by viewing the plan formulary at bcbstx.com. If the formulary indicates you need prior authorization or step therapy (which may require the previous use of one or more medications before coverage for a specific drug is provided), your physician will need to submit a request form to BCBS for approval. Contact Member Services at (800) 521-2227 for assistance.

To find a Participating Pharmacy, visit www.bcbstx.com/onlinedirectory/index.htm or contact the Customer Service Helpline telephone number on your Identification Card.

When you go to a Participating Pharmacy:

• present your Identification Card to the pharmacist along with your Prescription Order,
• provide the pharmacist with the birth date and relationship of the patient,
• sign the insurance claim log,
• pay the appropriate Coinsurance Amount for each Prescription Order filled or refilled and the pricing difference when it applies to the Covered Drug you receive.

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

• the billed charges, or
• the contracting Allowable Amount as determined by the Claim Administrator, or
• other contractually determined payment amounts.

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

When you use a participating pharmacy, your cost is based on the contracting Allowable Amount — you will not have to pay any amount above the negotiated charge for covered expenses. You are responsible for any expenses incurred over the maximums as detailed under What’s Covered Under the Prescription Drug Benefit.
Non-Participating Pharmacy

If you have a Prescription Order filled or obtain a covered vaccination at a non-Participating Pharmacy, you must pay the Pharmacy the full amount of its bill and submit a claim form to the Claim Administrator with itemized receipts verifying that the Prescription Order was filled or a covered vaccination was provided. The Plan will reimburse you for Covered Drugs and covered vaccinations equal to:

- the Co-Share Amount indicated on your BCBSTX Schedule of Coverage, and
- less any pricing differences that may apply to the Covered Drug or covered vaccination you receive.

You are also responsible for any expenses incurred over the maximums as detailed under What’s Covered Under the Prescription Drug Benefit. Mail completed claim forms to:

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

Out-of-network prescription drug claim forms are available online at bcbstx.com/member/rx_drugs.html or on HR Connect at tsocorp.com/hrconnect. Click on “Departments,” then “Human Resources,” then “My Benefits,” then “Benefit Forms,” then “Pharmacy Claim Form.”

Using the Mail-Order Pharmacy

All prescriptions and refills for a 31- to 90-day prescription drug supply must be filled by the BCBSTX mail-order pharmacy, PrimeMail. For the PPO Base Plan, Traditional Plan and Out-of-Area Plan options, you will receive a 90-day supply through mail-order for the cost of a 60-day supply through retail. For the Value Plus Plan, you will pay 10% coinsurance after your calendar year deductible is met. To obtain a mail-order prescription, use the Mail-Order Drug Form available on HR Connect at tsocorp.com/hrconnect and at www.bcbstx.com/member/rx_drugs.html, or contact Customer Service at the toll-free number on your Identification Card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form:

Blue Cross and Blue Shield of Texas
c/o Prime Mail Pharmacy
P. O. Box 650041
Dallas, TX 75265-0041

Specialty Pharmacy Program

The Specialty Pharmacy Program offers a Specialty Drug delivery service and integrates benefits for Specialty Drugs with the Participant’s overall medical and prescription drug benefits. This program provides the option of having delivery of these drugs made directly to the Participant’s Health Care Practitioner, to the location where the drug will be administered, or to the Participant’s residence.

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

- Coordination of coverage among the Participant, the Health Care Practitioner and BCBSTX,
- Educational materials about the patient’s particular condition and information about managing potential medication side effects,
- Syringes, sharps containers, alcohol swabs and other supplies with every shipment for FDA approved self-injectable medications, and
- Access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days each year.

If you and your covered Dependents use the Specialty Pharmacy Program, you should contact Customer Service at the toll-free number on your Identification Card for information about how to submit your Prescription Orders. You will also be given information on how to make payment for your share of the cost.

A list identifying these Specialty Drugs is available by accessing the website at www.bcbstx.com and following the link to the specialty prescription drug list. You may also contact Customer Service at the toll-free number shown in the BCBSTX Plan Document or on your Identification Card for information pertaining to the specialty prescription drug list.

**Emergency Prescriptions**

When you need a prescription filled in an emergency or urgent care situation, or when you are traveling:

You can obtain in-network benefits by filling your prescription at any participating retail pharmacy. The pharmacy will fill your prescription and charge you the applicable copay, deductible or coinsurance amount.

If you use a non-participating pharmacy, you will pay the full cost of the prescription drugs and then file a claim for reimbursement. You will be reimbursed for your covered expenses up to the cost of the prescription, less any applicable deductibles or coinsurance.

**GENERIC VS. BRAND NAME**

There is very little difference between generic and brand name medications, except cost. If your physician prescribes a covered brand name prescription drug when a generic equivalent is available and specifies “Dispense As Written” (DAW), you will pay the applicable cost for the brand name prescription.

If you request a covered brand name prescription drug when a generic equivalent is available, you will be responsible for the cost difference between the brand name and the generic equivalent, plus your required copay, deductible and/or coinsurance.

**Preferred Drug List**

Your prescription drug benefit coverage is based on BCBSTX’s Preferred Drug List, which includes both brand name and generic prescription drugs. Your out-of-pocket expenses may be higher if your physician prescribes a covered prescription drug not appearing in the Preferred Drug Guide.

Generic prescription drugs may be substituted by your pharmacist for brand name prescription drugs. You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available.

To find out if your prescription is part of the Preferred Drug List, log onto bcbstx.com or call the Customer Service Helpline telephone number on your Identification Card.
## WHAT’S COVERED – PRESCRIPTION DRUG BENEFIT DETAILS

The following chart gives additional benefit descriptions, explanations and limitations for certain covered expenses. More coverage details are available in the BlueCross BlueShield of Texas Plan Document. See the Prescription Drug Summary Chart to review the deductibles, copays and/or coinsurance that apply to covered expenses under each plan option. See Preauthorization Requirements for expenses requiring preauthorization.

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Pharmacy Benefits</td>
<td>Includes coverage for participating and non-participating retail pharmacies, but you will pay more if you choose a non-participating pharmacy. Retail prescriptions are limited to a maximum 30-day supply. Prescriptions for more than a 30-day supply are not eligible for retail pharmacy coverage.</td>
</tr>
<tr>
<td>Mail-Order Pharmacy Benefits</td>
<td>Outpatient prescription drugs are covered when dispensed by the mail-order pharmacy. Each mail-order prescription is limited to a maximum 90-day supply. Prescriptions for less than a 31-day supply or more than a 90-day supply are not eligible for mail-order pharmacy coverage.</td>
</tr>
<tr>
<td>Contraceptives and Contraceptive Devices</td>
<td>Contraceptive drugs and devices obtained from a Participating Pharmacy that are identified on the BCBSTX website under Contraceptive - Pharmacy information (referenced in the medical portion of the Plan as part of Benefits for Preventive Care Services) will not be subject to Deductibles, Copayment Amounts and Co-Share Amounts. Additional contraceptive drugs are covered under the Pharmacy portion of the Plan and are subject to the applicable Deductibles, Copayment Amounts, Co-Share Amounts, and any pricing differences. Implantable contraceptives and IUDs are covered when obtained from a physician. The physician will provide insertion and removal of the drugs or device.</td>
</tr>
</tbody>
</table>
| Diabetic Supplies                        | Benefits are available for Medically Necessary items of Diabetes Supplies for which a Physician or authorized Health Care Practitioner has written an order. Such Diabetes Supplies, shall include but not be limited to the following:  
• Test strips specified for use with a corresponding blood glucose monitor  
• Lancets and lancet devices  
• Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein  
• Insulin and insulin analog preparations  
• Injection aids, including devices used to assist with insulin injection and needleless systems  
• Insulin syringes  
• Biohazard disposable containers  
• Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and  
• Glucagon emergency kits |
| Phenylketonuria or Other Heritable Diseases | Benefits are available for dietary formulas necessary for the treatment of phenylketonuria or other heritable diseases. |
| Injectable Drugs                         | Injectable drugs approved by the FDA for self-administration are covered under the Plan.                                                                                                                                                                                                                 |
| Lifestyle/Performance Drugs              |  
• Coverage is limited to 12 pills per retail 30-day supply.  
• Mail-order and 60 to 90-day supplies are not covered. |
| Smoking Cessation Aids                  | Prescription drugs for smoking cessation and the treatment of nicotine addiction are covered.                                                                                                                                                                                                                           |
### Specialty Drugs

Benefits are available for Specialty Drugs. Specialty Drugs are generally prescribed to treat a chronic complex medical condition. They often require careful adherence to treatment plans and have special handling and storage requirements. You must obtain these drugs from the Specialty Pharmacy Program (see Specialty Pharmacy Program).

### Select Vaccinations Obtained Through Participating Pharmacies

Benefits for covered vaccinations are available through certain Participating Pharmacies that have contracted with BCBSTX to provide this service. To locate one of these contracting Participating Pharmacies in your area, and to determine which vaccinations are covered under this benefit, call the Customer Service Helpline number on your Identification Card. At the time you receive services, present your BCBSTX Identification Card to the pharmacist. This will identify you as a Participant in the BCBSTX health care plan provided by your employer. The pharmacist will inform you of the appropriate cost share, if any.

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

- Childhood immunizations subject to state regulations are not available under these Pharmacy Benefits. Refer to What’s Covered – Medical Coverage Details for benefits available for childhood immunizations.
Prescription Drug Benefit Limitations and Exclusions

The Plan covers only prescription drugs, services and supplies that are medically necessary. This section includes expenses that are not covered or that are subject to special limitations. These exclusions are in addition to the exclusions listed under medical coverage. Pharmacy benefits are not available for:

- Drugs which do not by law require a Prescription Order from a Provider or authorized Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and vaccinations administered through certain Participating Pharmacies as shown on your BCBSTX Schedule of Coverage); and Legend 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 therapeutic devices, including support garments and other non-medicinal substances, artificial appliances, or similar devices (provided that disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies shall be specific exceptions to this exclusion). NOTE: Coverage for the rental or purchase of a manual, electric, or Hospital grade breast pump and female contraceptive devices is provided as indicated under the medical portion of this Plan.
- 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 injected, ingested or applied in a Physician's or authorized Health Care Practitioner's office or during confinement while a patient is in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies provided or available in connection with an occupational sickness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality, or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this section shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any special services provided by the Pharmacy, including but not limited to, counseling and delivery. Vaccinations administered through Pharmacies are an exception to this exclusion.
- Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Participant's cost share determined under this Plan.
- Non-prescription contraceptive materials, (except prescription contraceptive drugs which are Legend Drugs. Contraceptive drugs provided by a Participating Pharmacy will not be subject to Co-Share Amounts, Deductibles, Copayment Amounts and/or dollar maximums as shown in Benefits for Preventive Care Services.)
- Any non-prescription contraceptive medications or devices for male use.
- Oral and injectable infertility and fertility medications.
- 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.
- Drugs dispensed in quantities in excess of the day supply amounts stipulated in your BCBSTX Schedule of Coverage, certain Covered Drugs exceeding the clinically appropriate predetermined quantity, or refills of any prescriptions in excess of the number of refills specified by the Physician or authorized Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
• Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), unless approved by the FDA for self-administration, intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting. NOTE: This exclusion does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

• Drugs, that 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 your Employer’s group health care plan, 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.

• Compounded drugs that do not meet the definition of Compound Medications according to the Claims Administrator.

• Compounded medications for patients older than the age of 12.

• Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

• Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s) in the same strength, unless otherwise determined by the Plan.

• Retin A or pharmacologically similar topical drugs after the age of 19.

• Athletic performance enhancement drugs.

• Bulk powders.

• Surgical supplies.

• Ostomy products.

• Diagnostic agents. This exclusion does not apply to diabetic test strips.

• Drugs used for general anesthesia.

• Allergy serum and allergy testing materials.

• Injectable drugs or Specialty Drugs except those approved by the FDA for self-administration.

• Some equivalent drugs manufactured under multiple brand names. BCBSTX may limit benefits to only one of the brand equivalents available. If you do not accept the brand that is covered under this Plan, the Brand Name Drug purchased will not be covered under any benefit level.

• Specialty Drugs unless obtained through the Specialty Pharmacy Program.

• Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.

• Shipping, handling or delivery charges.

• Drugs that are repackaged by anyone other than the original manufacturer.

• Prescription Orders written by a member of your immediate family, or a self-prescribed Prescription Order.
HOW TO FILE A CLAIM FOR BENEFITS

Medical and prescription drug claim forms are available through the Andeavor intranet and the Andeavor Benefit Center (see Contacts).

Medical Claims

If You Use a Network/Participating Provider

Your provider files the claim on your behalf

When you receive treatment or care from a Network/Participating Provider or Covered Drugs dispensed from a Pharmacy that contracts with the Claim Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claim Administrator for you.

If You Use an Out-of-Network Provider

Your provider MAY file the claim. However, you are responsible for making sure this happens.

When you receive treatment or care from a health care Provider or Covered Drugs dispensed from a Pharmacy that does not contract with the Claim Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, you must file your own claim forms.

Even if an out-of-network provider submits a claim on your behalf, it is still your responsibility to ensure that the claim is submitted in a timely fashion.

You should promptly submit claims to the Claims Administrator. All claims for benefits under the Health Benefit Plan must be properly submitted to the Claim Administrator within twelve (12) months of the date you receive the service or supplies.

Filing Your Medical Claim

If your Provider does not submit your claims, you will need to submit them to the Claim Administrator using a subscriber-filed claim form provided by the Plan. You can obtain copies of the form from HR Connect at tsocorp.com/hrconnect or from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim.

Remember to file each participant’s expenses separately because any deductibles, maximum benefits, and other provisions are applied to each participant separately. Include itemized bills from the health care providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the participant involved.

Be sure to read the instructions on the claim form carefully and complete and sign all claims completely and accurately. If you submit an incomplete or inaccurate form, processing of the claim will be delayed while the necessary information is obtained.

Where to Send Medical Claims

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

When you receive Covered Drugs dispensed from a non-Participating Pharmacy, a Prescription Reimbursement Claim Form must be submitted. This form can be obtained from the Claim Administrator or HR Connect at tsocorp.com/hrconnect.

The claim form, accompanied by an itemized bill obtained from the Pharmacy showing the prescription services you received, should be mailed to the address shown below or on the claim form.

Instructions for completing the claim form are provided on the back of the form. You may need to obtain additional information, which is not on the receipt from the pharmacist, to complete the claim form.

Bills for Covered Drugs should show the name, address and telephone number of the Pharmacy, a description and quantity of the drug, the prescription number, the date of purchase and most importantly, the name of the Participant using the drug.

You can review your benefit claims by logging onto www.bcbstx.com. If you have any questions about your claims for medical or prescription drug benefits, call the Customer Service Helpline at (800) 521-2227.

Where to Send Prescription Claims

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

Mail-Order Program Claims

Blue Cross and Blue Shield of Texas
c/o Prime Mail Pharmacy
P. O. Box 650041
Dallas, TX 75265-0041

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claim Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Payment of Claims

Regardless of who receives the benefits under the Plan (you or your dependents), payment of the claim will be made directly to you — the employee — except under these circumstances:

• payment will be made directly to the provider for network services; or
• payment may be made to an alternate payee or legal representative in the case of a QMCSO (see Qualified Medical Child Support Orders (QMCSOs)).

After your claim has been processed, you will receive an Explanation of Benefits (EOB) statement. The EOB includes the following information:

• all charges that were submitted;
• what benefits were covered under the Plan;
• the amount paid to the provider and to you;
• an explanation of how the benefit amounts were determined; and the amount you are responsible for paying.

The Claim Administrator for the Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.
ASSIGNMENT AND PAYMENT OF BENEFITS

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided. In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan’s responsibility to the Employee or Dependents for benefits available under the Plan.

Types of Claims and Timeframes

Depending on the type of claim, different rules may apply. The following are types of claims under the Plan: post-service claims; pre-service claims; and urgent care claims.

Post-Service Claims

Post-service claims are claims filed for payment of benefits after medical care has been received. Most claims are post-service claims. Within 30 days following receipt of a post-service claim, the Claims Administrator will either:

• pay all benefits payable;
• deny the claim in whole or in part; or
• request additional information.

The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension of up to an additional 15 days.

• Once notified of the need to provide additional information, you will have 45 days to provide the information.
• The period for the Claims Administrator to make a determination on your claim will be tolled from the date on which the notice of extension is provided until the date on which you respond with the requested information.
• If you do not provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial (including the part of the Plan on which the denial is based) and the claim appeal procedures.

Pre-Service Claims

Pre-service claims are claims that require notification or approval prior to receiving medical care. If your pre-service claim was submitted properly, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If your pre-service claim was filed improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days after receipt of the claim.

If additional information is needed to process the claim, the Claims Administrator will notify you within 15 days of receipt and may request a one-time extension of up to an additional 15 days.

• Once notified of the need to provide additional information, you will have 45 days to provide the information.
• If all of the information is received by the Claims Administrator within the 45-day timeframe, the Claims Administrator will notify you of the determination within 15 days after the information is received.
• If you do not provide the needed information within the 45-day period, your claim will be denied.

You will be notified of the decision, whether adverse or not, as soon as possible but not later than the last day of the applicable period for reviewing the claim. A denial notice will explain the reason for denial (including the part of the Plan on which the denial is based) and the claim appeal procedures.

Urgent Care Claims

Urgent care claims are claims that require notification or approval prior to receiving medical care, where a delay in treatment:

• could seriously jeopardize your life or health or your ability to regain maximum function; or
• in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
For an urgent care claim, you or your physician should call the Claims Administrator as soon as possible. The claim does not need to be submitted in writing.

If the Claims Administrator or your physician determines that it is an urgent care claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If your urgent claim was filed improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after receipt of the claim.

If additional information is needed to process the claim, the Claims Administrator will notify you within 24 hours of receipt, and you will have 48 hours to provide the requested information. You will be notified of a determination no later than 48 hours after the earlier of:

• the Claims Administrator’s receipt of the requested information; or
• the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial (including the part of the Plan on which the denial is based) and the claim appeal procedures.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the Claims Administrator and receive a decision on that appeal before the termination or reduction takes effect.

If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

**IF A CLAIM FOR BENEFITS IS DENIED**

Appealing a Denied Claim

Whenever a claim is denied, you, your beneficiary(ies) or a duly authorized representative have the right to appeal the decision. If you have a question or concern about a benefit determination, you should first call the Customer Service Helpline before requesting a formal appeal. If you still wish to submit a formal appeal, you can submit a written appeal to the Claims Administrator at:

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

If the appeal relates to a claim for payment, your written appeal to the Claims Administrator should include:

• the group name (employer name);
• the patient’s name and the identification number from the ID card;
• the date(s) of medical service(s);
• the provider’s name;
• the reason you believe the claim should be paid; and
• any documentation or other written information to support your request for claim payment.

Your appeal must be submitted to the Claims Administrator within 180 days after you receive the claim denial. If an appeal is not made within the 180-day period, the denial will be considered final, conclusive and binding.
IMMEDIATE ACTION — URGENT CARE CLAIM APPEALS

Your initial claim for benefits may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- the appeal does not need to be submitted in writing;
- you or your physician should call the Claims Administrator as soon as possible; and
- the Claims Administrator will provide you with a written or electronic determination within 72 hours after receipt of your appeal, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer provisions of the Plan for urgent care claim appeals. The Claims Administrator’s decision is conclusive and binding, except to the extent explained in the External Review section below.

To make a determination on your appeal, the Claims Administrator:

- will appoint a qualified individual to resolve or recommend the resolution of the appeal. Neither this individual nor his subordinate will have been involved in the decision being appealed;
- will consult with a health care professional who was not involved in the initial determination with appropriate expertise in the field (if the appeal is related to clinical matters); and
- may consult with, or seek the participation of, medical experts as part of the appeal resolution process.

By requesting an appeal, you consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits.

Determinations for Appeals

For appeals of pre-service claims, post-service claims and urgent care claims, the Claims Administrator will conduct the appeal and provide you written or electronic notification of the decision:

- within 30 days from receipt of a request for appeal of a denied pre-service claim;
- within 60 days from receipt of a request for appeal of a denied post-service claim; and
- within 72 hours after receipt of your appeal of a denied urgent care claim, taking into account the seriousness of your condition.

External Review

Notwithstanding any determination made by the Claims Administrator during the claims process, certain determinations made by the Claims Administrator are subject to an External Review process, upon your request. A request for External Review must be filed with the Claims Administrator within 4 months of the date of adverse benefit determination under the internal appeal process. The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (whether as an initial denial or upon internal appeal) conducted by an independent review organization (IRO) pursuant to applicable law. The decision of the IRO is binding on you, the Claims Administrator and the Plan unless otherwise allowed by law.

Only the following types of claims are eligible for External Review:

- a claim that relates to a rescission, which is defined as a cancellation or discontinuance of coverage which has retroactive effect, or
- a claim that involves medical judgment

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review. Your request for External Review of an eligible claim will be provided if the following are satisfied:

- The Claims Administrator, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law, unless such failure constitutes a “de minimis violation”; or
- the standard levels of internal appeal have been exhausted.
A failure to abide by the internal claims procedure will not be considered “de minimis violation” unless the Claims Administrator determines that the violation does not cause, or is not likely to cause, prejudice or harm to the participant so long as the Claims Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Claims Administrator and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the participant. For these purposes, the participant may request an explanation of the basis upon which the Claims Administrator asserts that such violation does not result in a deemed exhaustion of these claims procedures with respect to a claim, which shall be provided to the participant within ten (10) days of such request. If an IRO or court rejects the participant’s request for immediate review based on the Claims Administrator’s assertions, the Claims Administrator shall, within ten (10) days thereof, notify the participant of the opportunity to resubmit and pursue the internal appeal of such claim(s) in accordance with the foregoing claims procedures, and the otherwise applicable time period shall begin to run as of the date of such notice to the participant.

Within five (5) business days following the date of its receipt of a claimant’s request for an External Review of a claim for benefits, the Claims Administrator or its delegate shall complete a preliminary review of the request for External Review to determine the following:

- Whether the Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- Whether the Adverse Benefit Determination relates to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- Whether the claimant has exhausted (or is deemed to have exhausted) the Plan's internal claims procedures; and
- Whether the claimant has provided all the information and forms required to process the request for an External Review of the claim for benefits.

**Notice to Claimant**

**Ineligible Claim.** If the claimant’s request for External Review is complete, but the claim is not eligible for an External Review, the Claims Administrator or its delegate shall, within one (1) business day following completion of its preliminary review, provide the claimant with written notice of the reason(s) for the claim’s ineligibility for External Review and the contact information for the Employee Benefits Security Administration (toll-free number (866) 444-EBSA (3272)).

**Incomplete Request.** If the claimant’s request for External Review is incomplete, the Claims Administrator or its delegate shall, within one (1) business day following completion of its preliminary review, provide the claimant with written notice describing the information or materials needed to complete the request for External Review and the Plan shall provide the claimant an opportunity to perfect the request for External Review within the later of the applicable four-month filing period described above or the 48-hour period following the receipt of the notification, whichever is later.

**Referral to Independent Review Organization.** Upon receipt of a completed and eligible request for External Review, the Plan must, in accordance with applicable law, assign an IRO to conduct the External Review. Within five (5) business days following the date of assignment of the IRO, the Plan shall provide to the IRO the documents and any information considered in making the Adverse Benefit Determination. With respect to a Claimant’s request for an expedited External Review, the Plan must provide or transmit such information to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. Notwithstanding the foregoing, the Plan’s failure to timely provide the documents and information shall not delay the External Review. If the Plan fails to timely provide the documents and information, the IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination. Within one (1) business day after making the decision to terminate the External Review and reverse the prior Adverse Benefit Determination, the IRO must notify the claimant and the Plan of its determination.
Communication by Independent Review Organization. The IRO will notify the claimant, in writing, of the eligibility and acceptance of the claim for External Review, and will include a statement that the claimant may, within ten (10) business days following the date of receipt of such notice, submit, in writing, to the IRO additional information for the IRO to consider when conducting the External Review of the claim for benefits. Upon receipt of any information submitted by the claimant, the IRO must within one (1) business day forward the information to the Plan.

Reconsideration by Plan. Upon receipt of any information forwarded by the IRO, the Plan may reconsider its Adverse Benefit Determination that is the subject of the External Review. Reconsideration by the Plan shall not delay the External Review of the claim for benefits. Notwithstanding the foregoing, if the Plan decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination and provide coverage or payment, the External Review of the claim for benefits may be terminated. Within one (1) business day after making such decision, the Plan must provide written notice of its decision to the claimant and the IRO. The assigned IRO must terminate the External Review upon receipt of the notice from the Plan.

Review by Independent Review Organization. In conducting its review, the IRO shall consider the information forwarded by the Plan and any additional information and documents timely submitted by the claimant and shall utilize legal experts where appropriate to make coverage determinations under the Plan. In reaching its decision, the IRO will review the claim de novo and shall not be bound by any decisions or conclusions reached during the Plan's internal claims process. In addition to the documents and information provided by the Plan and the claimant, the IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following information in reaching a decision on External Review:

1. The Participant's medical records;
2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan, claimant, or the Participant's treating provider;
4. The terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations;
6. Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
7. The opinion of the IRO's clinical reviewer or reviewers after considering the information to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

Decision by Internal Review Organization. The IRO must, within forty-five (45) days after the IRO receives the request for the External Review, provide written notice of the Final External Review Decision to the claimant and the Plan. Notwithstanding the foregoing, with respect to a claimant’s request for an expedited External Review of a claim for benefits, the IRO shall provide notice of the Final External Review Decision to the claimant as expeditiously as the Participant’s medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the claimant’s request for an expedited External Review of the claim for benefits. Notice of the Final External Review Decision may be given orally, but only if the IRO furnishes the claimant a written notification of the Final External Review Decision within forty-eight (48) hours after the date of providing the oral notice.

Contents of Notice. The notice of the Final External Review Decision by the IRO shall set forth the following:
1. A general description of the reason for the Claimant’s request for an External Review of the claim for benefits, including information sufficient to identify the claim (including the date or dates of service, the Health Care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
2. The date the IRO received the assignment to conduct the External Review of the claim for benefits and the date on which the Final External Review Decision was made;
3. References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching the Final External Review Decision;
4. A discussion of the principal reason or reasons for the Final External Review Decision, including the rationale for the Final External Review Decision and any evidence-based standards that were relied on in making the Final External Review Decision;
5. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the Plan or to the Claimant;
6. A statement that judicial review may be available to the Claimant; and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act.

Retention of Records. Following a Final External Review Decision, the IRO must maintain records of all claims and notices associated with the External Review of a claim for benefits for six (6) years and must make such records available for examination by the claimant, the Plan, or any state or federal oversight agency, upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of Adverse Benefit Determination. Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim, regardless of whether the Plan intends to seek judicial review of the Final External Review Decision and unless or until there is a judicial decision.

Expedited External Review. You may request an expedited External Review at the time the Claimant receives:
1. An Adverse Benefit Determination that involves a medical condition of the Participant for which the timeframe for completion of an expedited Internal Appeal would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function and with respect to which the claimant has filed a request for an expedited Internal Appeal; or
2. An Adverse Benefit Determination, if the Participant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Participant or would jeopardize the Participant's ability to regain maximum function, or if the Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Participant received emergency services, but has not been discharged from a facility.

Exhaustion of Appeals Process
You must exhaust the appeals process before you pursue other action. After that you may pursue litigation, arbitration or administrative proceedings.

You may not pursue your claim in state or federal court until you have first exhausted the claims procedures under the Plan. No legal action may be brought after three years from the date participation in the Plan ends or, if earlier, the date the claim is denied following exhaustion of the appeal procedures outlined above.
COORDINATION OF BENEFITS (COB)

Coordination of benefits (COB) applies when you or your covered dependents have health care coverage under more than one plan or other program. In these situations, it’s necessary to determine which plan has primary responsibility for the payment of benefits.

When COB Is Applicable

The COB provision applies to this Plan when you or your covered dependent has health care coverage under more than one plan. If you or a covered dependent are covered under more than one plan and you incur an expense that is covered — partially or in full — under this Plan and at least one other plan:

- benefits related to that expense will be paid under the Primary and Secondary Plans as determined under the COB provisions; and
- under no circumstances will the sum of the benefits paid from each plan exceed the actual expense incurred.

How COB Works

The order of benefit determination rules determine which plan will pay as the Primary Plan. When an individual is covered under more than one plan:

- one plan is determined to be the Primary Plan and the others are considered Secondary Plans;
- the Primary Plan pays or provides its benefits first as if the Secondary Plan(s) did not exist;
- when this Plan is secondary, it pays after the Primary Plan and may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan; and
- when this Plan is secondary, it will credit to its Plan deductible any amounts that would have been credited in the absence of other coverage. In determining the amount to be paid when this Plan is secondary, this Plan will calculate the benefits that it would have paid on the claim in the absence of other plan(s) and apply that amount to any allowable expense under this Plan that was unpaid by the Primary Plan.

This Plan will not pay more than it would have paid without the COB provision. In order to pay claims, the Claims Administrator must determine the Primary Plan and the Secondary Plan(s).

Determination of Primary and Secondary Plans

A plan that does not contain a coordination of benefits provision that is consistent with this provision is always the Primary Plan, with two exceptions:

- Coverage that is designed to supplement a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder.
- Examples of these types of coverages are:
  - major medical coverages that are superimposed over base plan hospital and surgical benefits, and
  - insurance-type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- Automobile insurance coverage that is mandatory under state law, whether or not the Participant is in compliance with such mandate.
The first of the following rules that describes which plan pays its benefits first will be the rule that applies:

1. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent — for example as an employee, member or subscriber — is primary, and the plan that covers the person as a dependent is secondary.
   However, if the person is a Medicare beneficiary, and by federal law Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person other than as a dependent, then the order of benefits is reversed, so that the plan covering the person as an employee, member or subscriber is secondary and the other plan is primary.

2. **Child Covered Under More than One Plan.** The order of benefits is:
   A. The Primary Plan is the plan of the parent whose birthday (month and day of birth) is earlier in the year if:
      i. The parents are married and are not legally separated; or
      ii. A court order awards joint custody without specifying that one party has responsibility to provide health care coverage, or states that both parents are responsible for health care coverage.
   
   Note: If both parents have the same birthday, the plan that has covered a parent longer is primary.

   B. If the terms of a court order state that one of the parents is responsible for health care coverage and the plan of that parent is aware of those terms, that plan is primary. If the parent with responsibility has no health care coverage but that parent’s spouse does, the plan of the parent’s spouse is primary.

   C. If the parents are separated or divorced, or are not living together whether or not they have ever been married, and there is no court order assigning responsibility for health care coverage, the order of benefits is:
      i. The plan of the custodial parent;
      ii. The plan of the spouse of the custodial parent;
      iii. The plan of the noncustodial parent; and then
      iv. The plan of the spouse of the noncustodial parent.

   Note: For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as shown above as if the individuals were the parents.

3. **Active Employee or Retired or Laid Off Employee.** The plan that covers a person as an active employee (neither laid off nor retired) or as a dependent of an active employee is the Primary Plan. The plan covering the same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the Secondary Plan.

4. **Continuation Coverage.** If a person whose coverage is based on continuation rights under federal or state law is also covered under another plan, the plan covering the person as an employee, member or subscriber (or as that person’s dependent) is primary, and the continuation coverage is secondary.

5. **Longer or Shorter Length of Coverage.** The plan that has covered the person as an employee, member or subscriber longer is primary.

6. **If the preceding rules do not determine the Primary Plan,** allowable expenses (expenses covered at least in part by any of the plans covering the person) will be shared equally between the plans. However, this Plan will not pay more than it would have paid had it been primary.
If your spouse is covered under the Plan but is also covered under another group plan, your spouse’s group plan will always be the Primary Plan for your spouse. If a person is covered under this Plan both as an employee and a dependent, or as a dependent of two employees, each instance of coverage will be treated as a separate plan for purposes of calculating benefits under the multiple coverages.

In order to avoid delays in claims processing, your claims should be submitted to the Primary Plan as soon as possible. When you file a claim, you will have to give information about any other plans under which you are covered.

- To facilitate COB processing when you or your dependents have other insurance, you should notify the Claims Administrator at the Customer Service Helpline.
- If this Plan is the Secondary Plan, you or your provider should submit a copy of the Explanation of Benefits (EOB) from the Primary Plan, along with an itemized statement of expenses and a claim form, if necessary, for benefits consideration.
- For non-Medicare claims, this Plan will consider benefit payments you receive from the Primary Plan. The Plan makes up the difference up to the maximum amount the Plan would have paid if there were no other medical coverage.

**Medicare Coordination**

Your benefits under the Plan may be coordinated and, in some cases, reduced by benefits that you receive (or would have received) from other plans or under other coverage, including Medicare. To the extent required by federal law, however, this Plan will be considered Primary to Medicare. Accordingly, your benefits under the Plan as an active employee will not be reduced as a result of eligibility or entitlement to Medicare, regardless of whether such eligibility or entitlement is a result of your attainment of age 65 or due to a disability.

However, in the event that you become eligible for or entitled to Medicare as a result of end-stage renal disease (ESRD), the Plan will be considered Primary to Medicare only during the thirty (30) month period commencing on the earlier of such dates. Thereafter, the Plan becomes Secondary to Medicare and your benefits under the Plan will be reduced by the amounts payable by Medicare for such services or treatments.

Medicare will be primary to benefits under this plan for inactive participants who are eligible for Medicare, including those in LTD or retirement status.

**Impact of Medicare Prescription Drug Coverage (Part D)**

When you are enrolled in this Plan, you have prescription drug coverage as part of your Medical Plan. The cost of this coverage is already included in the premium you pay for the Plan. The prescription drug benefit offered under this Plan has been determined to be better than the coverage available through Medicare Part D. If you enroll in Medicare Part D, you will be paying an additional premium for coverage that is not as extensive as the Andeavor Plan.

It may not be to your advantage to enroll in Medicare Part D unless you qualify for the extra financial assistance available to people with limited income and resources. If you enroll in the Andeavor Plan but wish to enroll in Medicare Part D in the future, you will be able to do so without the penalty that Medicare otherwise would apply to those enrolling in Part D after May 15, 2006. This is because the Andeavor Plan provides “creditable coverage” — benefits that are at least as good as, or better than, Medicare’s prescription drug benefit.

**Rescission**

Rescission is the cancellation or discontinuance of coverage that has retroactive effect. Your coverage may not be rescinded unless you or a person seeking coverage on your behalf performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact. A cancellation or discontinuance of coverage that has only prospective effect is not a rescission. A retroactive cancellation or discontinuance of coverage based on a failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums) is not a rescission. You will be given 30 days advance notice of rescission. A rescission is considered an Adverse Benefit Determination for which you may seek internal review and external review.
Rights of Recovery

Overpayment of Benefits

If the Plan pays benefits, the Plan has the right to recover the overpayment if either of the following apply:

• all or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person; or
• all or some of the payment exceeded the benefits available under the Plan.

The covered person, another person or the organization that received the overpayment, must make a refund to the Plan.

If the covered person, or any other person or organization that was paid, does not promptly refund the full amount, the amount of any future benefit payments may be reduced.

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

Subrogation and Reimbursement

Under certain circumstances, the Plan will be entitled to recover, through either or both of its rights to reimbursement or subrogation, the cost of certain benefits previously provided to a covered individual as a result of an illness, injury or condition for which a Third Party is or may be held legally responsible. This section (Subrogation and Reimbursement) explains the circumstances under which the Plan will have these rights to recovery and your obligations under such circumstances. Please note that your failure to comply with the requirements of this section may result in a loss of coverage under the Plan.

There are important terms used throughout this section, the definitions of which are provided below:

• “Reimbursement” refers to the repayment by you of medical expenses previously paid by the Plan for an illness, injury or condition for which a Third Party is or may be held legally responsible.
• “Subrogation” refers to the substitution of you by the Plan with respect to a claim related to an illness, injury or condition of the covered individual for which a Third Party is or may be held legally responsible.
• “Third party” means any person other than the Plan, including, but not limited to, any one or more of the following: (i) the party or parties who caused the illness, injury, or condition, (ii) the insurer, guarantor, or other indemnifier of the party or parties who caused the illness, injury, or condition, (iii) the covered individual’s own insurer (for example, uninsured, underinsured, and no fault coverage), (iv) a worker’s compensation insurer, and/or (v) any other person, entity, policy, healthcare plan or insurer that is liable or legally responsible for the illness, injury, or condition.
• “You” or “your” refer to any individual covered under the Plan, as well as any person or entity (including but not limited to the estate or legal representative of a covered individual) that has or may recover a claim for benefits on behalf of a covered individual.

General: If you receive payment or reimbursement of medical expenses from the Plan, or you submit a claim to the Plan for payment or reimbursement of such expenses, which relate to the treatment of an illness, injury, or condition for which a Third Party is or may be held liable or legally responsible (for example, when the Plan pays claims for the treatment of an illness, injury or condition caused by an automobile accident or another person’s negligence), the payment, reimbursement, or claim, as applicable, will be subject to the Plan’s rights of reimbursement and subrogation as further described in this section.

Notice to Plan: You are required to notify the Plan of any payment, reimbursement or claim for medical expenses under the Plan that relates to the treatment of an illness, injury or condition for which a Third Party is or may be held liable or legally responsible. Such notice must be provided within thirty (30) days of the date when notice is provided to you (or your representative, including your attorney or insurer) of an intent to pursue or investigate a claim against a Third Party to receive damages or obtain another recovery due to the injury, illness, or condition sustained by the covered individual. Such notice must be provided directly to the Plan Administrator (see Additional Information for the Plan Administrator’s address).
Conditional Benefit Payments: The payment by or on behalf of the Plan of any claim for medical benefits for which a Third Party is or may be held liable or legally responsible is conditioned and contingent upon actual repayment to the Plan in the event of a recovery from a Third Party.

Lien: The Plan will have a first priority lien against, and will be entitled to recovery of, the first dollars paid or payable to you or on your behalf by a Third Party. It is important to note that the Plan’s lien applies regardless of how the claims, awards, recoveries or amounts paid or payable by or on behalf of a Third Party are classified or characterized by the parties, the courts or any other person or entity, including, for example, amounts paid to or for the benefit of the covered individual for general damages, and regardless of whether the covered individual is made whole for his or her losses and claim(s) for benefits following the Plan’s recovery, and regardless of whether the Third Party is at fault or has had made an admission of fault, and regardless of whether such amounts are paid pursuant to settlement, judgment or otherwise. The lien may be enforced against any person who possesses funds or proceeds representing the amount of benefits paid by the Plan.

The amount of the Plan’s lien will equal the lesser of the following amounts:

(A) the amount of benefits paid or payable by the Plan for the illness, injury, or condition, plus
   (i) the amount of all future benefits which may become payable under the Plan due to the illness, injury or condition,
   (ii) the costs and expenses incurred by the Plan in collecting such recovery from you and/or a Third Party, and
   (III) to the extent described below, interest on such amounts, or

(B) the amount recovered from the Third Party or parties.

Accordingly, the Plan will not seek recovery from you in excess of the amount payable to or on behalf of the covered individual from (i) any policy or contract from any insurance company or carrier (including, without limitation, the covered individual’s insurer) and/or (ii) any Third Party, plan or fund.

Constructive Trust: All payments received by you from a Third Party with respect to which the Plan has subrogation or reimbursement rights hereunder are subject to a constructive trust for the benefit of the Plan.

Reimbursement of Paid Expenses: Upon recovery of any amounts from a Third Party, you are required to reimburse the Plan first from such recovery for the amount of benefits paid by the Plan, if any, for the illness, injury, or condition to which the recovery relates, plus the costs and expenses incurred by the Plan in collecting such recovery from you or the Third Party. If you fail to reimburse the Plan within thirty (30) days of receipt of such recovery, the Plan may charge you interest on the amount you are required to reimburse the Plan in accordance with this provision. The rate of interest that may be recovered by the Plan will equal one and one-half percent (1½%) per month or the maximum amount permitted by applicable law, whichever is less, commencing on the date you recovered any such funds from a Third Party and ending on the date of reimbursement. All interest charged pursuant to this section will be added to the amount of the Plan’s lien, as described above.

Payment of Future Expenses: Upon recovery of any amounts from a Third Party, future expenses incurred by the covered individual that relate to the same illness, injury, or condition with respect to which you received such recovery will not thereafter be reimbursable from, or paid directly by, the Plan, unless otherwise provided in a separate written agreement signed by you and the Plan Administrator. Any funds paid or payable by a Third Party to or on behalf of the covered individual for future medical claims relating to the same illness, injury or condition for which the Third Party is, or may be, held liable or legally responsible are required to be set aside in an escrow account for the benefit of the covered individual. All benefits paid by the Plan with respect to such illness, injury or condition will be added to the amount of the Plan’s lien, as described above. As a result, the Plan will have the right to recover such amounts from the escrow account or directly from you.

No Offset of Costs: The Plan will not pay, offset any recovery, or in any way be responsible for any fees or costs associated with enforcing its reimbursement or subrogation rights under the Plan unless the Plan Administrator, in its sole and absolute discretion, agrees to do so in writing. All costs and fees incurred by the Plan to enforce its reimbursement and subrogation rights will be added to the amount of the Plan’s lien, as described above.

Subrogation of Rights Against Third Parties: The Plan will be subrogated to and will succeed to all claims, demands, actions and rights of recovery (under all possible legal theories) that you may have against any Third Party with respect to any illness, injury, or condition for which such Third Party may be held liable or legally responsible. This means that the Plan may, at its option, take over your right to pursue or receive payments from a Third Party, provided that the Plan’s recovery will not exceed the amount of the Plan’s lien described above.
Preservation of Rights: The Plan Administrator may, in its sole and absolute discretion, take any action as it deems necessary or appropriate to preserve the Plan’s rights to reimbursement and/or subrogation (including but not limited to the right to bring suit for imposition of a constructive trust or an injunctive order, file suit directly against a Third Party, or intervene in an action against a Third Party).

Cooperation and Assistance: You are required to cooperate in protecting the Plan’s rights to reimbursement and subrogation (including but not limited to providing notice of such claims to the Plan and holding recovered amounts in trust in satisfaction of the Plan’s rights), and may not act (or fail to act) at any time or in any manner that prejudices the Plan’s rights to reimbursement and/or subrogation (including but not limited to settling a claim with a Third Party without advance notice to and approval of the Plan Administrator). Accordingly, you are required to provide all information and sign and return all documents necessary for the Plan to exercise its rights to reimbursement and subrogation within five (5) business days of a request by the Plan Administrator or its representative. The Plan is permitted to investigate the circumstances surrounding your injury, illness or condition and identify and notify any Third Party that is or may be responsible for such injury, illness or condition of the Plan’s lien on amounts recovered by you.

Written Agreements: As a condition to the covered individual’s continued participation under the Plan, you may be required to execute a written agreement acknowledging the Plan’s rights of reimbursement and subrogation. Upon such request, and prior to the Plan’s receipt of an executed agreement, any claim related to the illness, injury or condition that is the subject of the reimbursement or subrogation rights of the Plan will be pended and will not be processed or paid. Failure of the Plan Administrator to require the execution of a written agreement from you does not act as a waiver of the Plan’s right to request a written agreement at any time or to pursue its rights to reimbursement and/or subrogation.

Failure to Comply: Your benefits under the Plan are conditioned on your compliance with the requirements related to the Plan’s rights to reimbursement and subrogation. Accordingly, your failure to comply with your obligations under this section constitutes wrongdoing and results in the wrongful payment of benefits under the Plan to or on behalf of the covered individual. If you do not reimburse the Plan such amounts, the Plan may take any action the Plan Administrator deems appropriate, including but not limited to the following:

- reducing future medical benefits that would otherwise be payable for any illness, injury or condition of the covered individual, regardless of whether such illness, injury or condition is related to the Third Party claim with respect to which the Plan’s reimbursement and subrogation rights relate, up to the amount of the Plan’s lien, as described above;
- terminating medical coverage under the Plan for the covered individual and his or her family members; and/or
- instituting court proceedings against you to recover amounts up to the amount of the Plan’s lien, as described above.

Additional Information: The Plan’s rights to reimbursement and subrogation will not be reduced as a result of the covered individual’s own negligence; or due to you not being made whole from the recovery from a Third Party; or as a result of attorney’s fees and costs incurred in the recovery from you or the Third Party. Specifically, but without limitation, the “make whole” doctrine does not apply to the Plan and the Plan is not subject to any state law doctrines, including, but not limited to, the common fund doctrine, which would purport to require the Plan to reduce its recovery by any portion of your attorney’s fees and costs.

Jurisdiction: By accepting benefits under the Plan, you have agreed to allow the Plan to institute any court proceedings to enforce its subrogation and reimbursement rights in any court of competent jurisdiction selected by the Plan and waive any right to contest such jurisdiction, regardless of your present or future residence.

Rescission of Coverage. In the event a Participant performs an act, practice or omission that constitutes fraud or makes an intentional misrepresentation of material fact, as determined in the sole discretion of the Plan Administrator, the coverage of such Participant, as well as that of the employee or former employee to whom such Participant’s coverage is attributable, if different, and of the dependents and beneficiaries of such employee or former employee, if different, shall be cancelled retroactively, subject to applicable law, to the date on which such act, practice or omission occurred, provided that the Plan Administrator provides written notice to each Participant (which, in the case of a minor or disabled Participant, shall be provided to the parent or other legal representative of such Participant) who would be affected by such retroactive cancellation of coverage no less than thirty (30) days prior to the date such cancellation of coverage is processed. For these purposes, a retroactive cancellation of coverage under the Plan due to the Participant’s failure to pay premiums or make applicable employee contributions is not subject to this notice requirement.
IF YOU TAKE A LEAVE OF ABSENCE

Your Medical Plan coverage will continue, and contributions will be deducted from your paycheck, during any Company-approved absences with full or adequate partial pay.

Your coverage will also continue as long as you remain eligible for the Plan and you are on:

• Long-Term Disability — receiving benefits from a Company-sponsored Long-Term Disability program;
• Personal Leave of Absence — for up to six months for Employer Certified leave;
• Family and Medical Leave under FMLA (Family and Medical Leave Act of 1993); or

Your coverage while on leave will be the same coverage that was in force on your last day of work as an active employee. However, any changes or reductions in benefits that apply to active employees after your leave begins will also apply to you.

You are allowed to waive your coverage while on a USERRA or FMLA leave of absence. If you wish to waive coverage during a paid leave, you must notify the Andeavor Benefit Center within 31 days of your leave start date.

Payment of Contributions While on Leave

If you are not receiving a paycheck, you must make the required contributions within a 30-day grace period in order to continue coverage. Contact the Andeavor Corporate Benefits Department to make payment arrangements.

If payments are not made within the 30-day grace period, coverage may be terminated once final written notice has been given with 15 work days to pay. If coverage is terminated during your FMLA leave due to non-payment of contributions:

• when you return to active employment, you will be eligible to enroll effective upon your return; and
• all previously owed contributions for the period of active coverage will be deducted from your paycheck.

If coverage is terminated during your non-FMLA leave due to non-payment of contributions, you will not be eligible to enroll until the next annual enrollment period. In addition to terminating coverage due to non-payment of contributions, coverage may also be terminated:

• upon expiration of your Long-Term Disability benefit;
• after six months on an Employer Certified Personal Leave of Absence if you do not return to employment; or
• if you do not return to employment at the end of your FMLA or USERRA leave of absence.

If you lose coverage under the Plan, you may be eligible to receive COBRA continuation coverage in certain situations (see Continuation of Coverage Under COBRA).
WHEN COVERAGE ENDS

Unless you are eligible to continue coverage as explained under Continuation of Coverage under COBRA, your coverage under the Plan will end if:

- the Plan is discontinued;
- you waive coverage during the open enrollment period or due to a qualified status change;
- you no longer meet the eligibility requirements for coverage under the Plan;
- you fail to make required contributions in a timely manner;
- you become enrolled in another Company-sponsored health care plan;
- you terminate employment and are not eligible to continue coverage as a retiree (see Retiree Coverage in box at right);
- you stop active employment and are not on a Company approved leave of absence;
- you lose your Long-Term Disability status under the Company-sponsored Long-Term Disability program and your Long-Term Disability benefits are discontinued; or
- you are on a Personal Leave of Absence and the leave extends beyond six months (you are only eligible for six months of continued medical coverage).

Unless your dependent is eligible to continue coverage as explained under Continuation of Coverage Under COBRA, coverage for your dependent(s) ends if:

- you fail to make required contributions for your dependent’s coverage;
- your own coverage ends for any of the reasons above;
- your dependent no longer meets the eligibility requirements for coverage under the Plan; or
- your dependent becomes an employee eligible for health care benefits under any health care plan offered by the Company.

If you are covering a domestic partner and your domestic partner’s children under the Plan, they will no longer be considered eligible dependents and coverage will end on the earlier of:

- the date the Plan no longer provides for such coverage; or
- the date your domestic partnership ends. In that event, you must provide the Company with a signed Benefits Change Form; or
- For the domestic partner’s child, the date such child no longer meets the Plan’s definition of “dependent” with respect to the domestic partner

Coverage for dependents may continue for a period after your death. For more information see Other Coverage Continuation Options.

Retiree Coverage

You may be eligible to continue coverage for yourself and your eligible dependents after you retire if you are participating in the Plan on the day before your retirement and you meet all post-retirement benefits eligibility criteria. Details on retiree medical plan coverage are in a separate Summary Plan Description.

Note: Retiree coverage is not available to employees hired (or rehired) on or after January 1, 2016.
CONTINUATION OF COVERAGE UNDER COBRA

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (known as “COBRA”), you and your eligible dependents that lose group health plan coverage may continue your coverage for a period of time. COBRA continuation rights are available if coverage is lost due to certain “qualifying events” (see COBRA Qualifying Events below). Your covered domestic partner and their covered children will be eligible for a continuation of benefit provision similar to COBRA if they lose coverage under the Plan due to a qualifying event.

COBRA continuation coverage with respect to the Plan is the same coverage that the Plan gives to other participants or dependents who are covered under the same option under the Plan and who are not receiving continuation coverage. Each person who elects COBRA continuation coverage will have the same rights under the Plan as other participants or dependents covered under the Plan, including special enrollment rights and the right to add or change coverage during the open enrollment period.

COBRA Qualifying Events

Employees
As an employee, you will be eligible for COBRA continuation coverage if you lose coverage due to:

• termination of employment, for reasons other than gross misconduct; or
• a reduction in hours of employment that results in loss of coverage.

Eligible Dependents
Your covered dependents will be eligible for COBRA continuation coverage if they lose coverage due to:

• your death;
• your termination of employment, for reasons other than gross misconduct;
• a reduction in your hours of employment that results in loss of coverage;
• your divorce or legal separation; or
• your dependent child no longer meeting the definition of a dependent child.

It is your or your covered dependent’s responsibility to notify the Andeavor Benefit Center (see Contacts) within 60 days of a qualifying event if your covered spouse or dependent child(ren) lose coverage under this Plan due to:

• divorce or legal separation; or
• your dependent’s loss of eligibility under the Plan.

If you notify the Andeavor Benefit Center more than 60 days after the qualifying event, your covered dependents may not be entitled to elect COBRA continuation coverage. Please note that you must provide notification in writing within 31 days (not 60) to comply with rules for changing your coverage level (see Changing Your Coverage).
Length of COBRA Coverage

COBRA is a temporary continuation of coverage. Depending on the qualifying event, coverage may be continued from the date coverage would otherwise end, as follows:

<table>
<thead>
<tr>
<th>COBRA Qualifying Event</th>
<th>Maximum Amount of Time Coverage May Continue Under COBRA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For You</td>
</tr>
<tr>
<td>You terminate employment (other than for gross misconduct) OR Your hours of employment are reduced, resulting in a loss of coverage</td>
<td>18 months (may be extended due to disability — see below)</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
<tr>
<td>You become entitled to Medicare</td>
<td>N/A</td>
</tr>
<tr>
<td>You divorce or legally separate</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child no longer meets the definition of a dependent child</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Extension of COBRA Coverage Due to Disability

You and each of your covered dependents may be eligible to extend your 18-month COBRA period to a total of 29 months if you or your covered dependent(s) is determined to be disabled under Title II or Title XVI of the Social Security Act at any time during the first 60 days of continuation coverage.

- To receive the extension, you must provide notice of the disability determination to the Andeavor Benefit Center (see Contacts) within 60 days of the date of the Social Security Administration’s determination and before the end of the initial 18-month continuation period.
- If you or your covered dependent(s) is later determined to not be disabled, you must notify the Andeavor Benefit Center within 30 days of the Social Security Administration’s determination. If the date of the determination is after the original 18-month COBRA period, your COBRA benefits will cease effective the date of determination.

If you and/or your covered dependent(s) are enrolled in COBRA continuation coverage and are determined to be disabled, contact the Andeavor Benefit Center to find out if you qualify for an extension of coverage.

Extension of Continuation Coverage Due to a Second Qualifying Event

If you are receiving COBRA continuation coverage as a result of your termination of employment or reduction in hours of employment, up to an 18-month extension of coverage may be available to your covered dependent(s) if a second qualifying event occurs during the first 18 months of COBRA coverage (or within the first 29 months in the case of a disability).
A second qualifying event includes:

- your death;
- your divorce or legal separation;
- your entitlement to Medicare; or
- your dependent child’s eligibility for coverage ends.

The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Note, however, if your first qualifying event was your entitlement to Medicare, the maximum amount of continuation coverage available for your spouse and dependents when a second qualifying event occurs is 36 months from the date on which you became entitled to Medicare. You must provide written notification to the Andeavor Benefit Center within 60 days after the second qualifying event occurs (see Contacts).

Enrolling in COBRA Coverage

Upon notification to the Andeavor Benefit Center of a COBRA qualifying event, COBRA election notices are prepared and mailed to your home address. Your medical coverage is discontinued as of the date of the event until a completed COBRA enrollment form, along with your contribution payment, is received. You and/or your covered dependent(s) will have 60 days from the date coverage would be lost due to a qualifying event (or the date you are notified of your right to continue coverage, if later) to elect COBRA continuation coverage.

You and each of your covered dependents may independently elect COBRA coverage. You or your spouse, however, may elect COBRA coverage on behalf of all the covered children who are under age 18.

If you choose to waive coverage during the 60-day election period, you may revoke the waiver in writing at any time before the 60-day period ends, and you will be entitled to COBRA continuation coverage as long as you and/or your covered dependent(s) meet all of the other conditions for continuation of coverage and the required contributions are paid on a timely basis.

If you do not elect continuation coverage, your benefits will terminate in accordance with the terms of the Plan.

Paying for COBRA Coverage

In order to continue your coverage under COBRA, you will be required to pay the full cost of coverage (your premium and the Company’s contribution), plus a 2% COBRA administration fee. If you or your covered dependent(s) is receiving the additional 11 months of COBRA coverage because of disability (see Extension of COBRA Coverage Due to Disability, the cost for each of those additional 11 months is 150% of the full monthly cost.

- The first payment of premiums will be due within 45 days of the date you elect to continue coverage.
- Premiums for coverage will be retroactive to the date you and/or your covered dependent(s) lost eligibility due to the qualifying event.
- Claims for reimbursement will not be processed and paid until you have elected COBRA continuation coverage and the first contribution payment has been timely paid and received.
- To continue COBRA coverage, you will need to make ongoing contribution payments. Each contribution payment is due on the first day of the month for which COBRA coverage is to be provided. If payment is not received by the 30th day following such due date, your COBRA coverage may be terminated.

If you do not make the full payment for any coverage period, COBRA coverage will be terminated retroactively to the end of the month for which the last full payment was made, and you will lose all rights to further COBRA continuation coverage under the applicable COBRA plan. Once coverage is terminated, it cannot be reinstated.
Adding Dependents During a COBRA Continuation Period

If through birth, adoption, marriage or completion of six months in a new domestic partnership, you acquire a new dependent during the continuation period, your dependent can be added to your coverage for the remainder of the continuation period if:

- he or she meets the definition of an eligible dependent (see Dependent Eligibility);
- you notify the Andeavor Benefit Center of your new dependent within 31 days of eligibility (see Contacts); and
- you pay any additional contributions for continuation coverage on a timely basis.

You must notify the Andeavor Benefit Center if, at any time during your continuation period, any of your covered dependents cease to meet the eligibility requirements for coverage.

Early Termination of COBRA Coverage

COBRA continuation coverage will end when the first of the following occurs:

- the Company no longer provides group medical coverage to its employees;
- you or your covered dependent(s) do not pay the premium on or before its due date;
- you and/or your covered dependents’ maximum COBRA continuation period ends;
- you become entitled to Medicare following an election of COBRA coverage;
- you or your covered dependent(s) becomes covered under another group health plan following an election of COBRA coverage. However, if the other plan contains an exclusion or limitation with respect to any preexisting conditions, you or your covered dependent(s) to whom such an exclusion or limitation applies may continue COBRA coverage under the Plan; or
- in the case of extended coverage due to disability (see Extension of COBRA Coverage Due to Disability), the disabled individual is no longer determined to be disabled under the Social Security Act.

You and/or your covered dependent(s) must notify the Andeavor Benefit Center if, after electing COBRA, you become entitled to Medicare, become covered under other group health plan coverage or are determined by the Social Security Administration to no longer be disabled.
OTHER COVERAGE CONTINUATION OPTIONS

In addition to the option to continue benefits under the provisions of COBRA, certain continuation benefits are available to your enrolled dependents if you die as an active employee.

There is no option to convert coverage to an individual policy.

Continuing Dependent Coverage After Your Death

If you die while enrolled in the Plan, your covered dependents may continue coverage under retirement provisions as long as:
• Were hired (or rehired) prior to January 1, 2016;
• you were eligible for post-retirement benefits, as defined by the Company (age + years of service is equal to or greater than 80, or age 55 with 5 years of service) at the time of death; and
• required payments are made for the coverage.

Note: Post retirement coverage for surviving dependent spouses ends at age 65. Post retirement coverage for surviving dependent children ends at age 26.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

If you are absent from employment for more than 30 days by reason of service in the uniformed services, you may elect to continue Plan coverage for you and your dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended.

The terms “uniformed services” or “military service” mean service in:
• the Armed Forces;
• the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training or full-time National Guard duty;
• the commissioned corps of the Public Health Service; and
• any other category of persons designated by the president in time of war or national emergency.

If qualified under USERRA, you may elect to continue coverage under the Plan by notifying the Andeavor Benefit Center and providing payment of any required contribution for coverage. You may be required to pay the full cost of coverage (employee and Company portions) plus a 2% administration fee.

You may continue Plan coverage under USERRA for up to the lesser of:
• the 24-month period beginning on the date of your absence from work; or
• the day after the date on which you fail to timely apply for, or return to, a position of employment.

For information regarding the applicable time period for reporting back to work or applying for reemployment, please contact the Plan Administrator. Regardless of whether you continue your coverage under the Plan during your military service, if you return to work within the time period prescribed by law, you and your eligible dependents’ coverage will be reinstated under the Plan.

No exclusions or waiting period may be imposed on you in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service. If your military service is less than 31 days, you may not be required to pay more than your regular contribution amount, if any, for continuation of health coverage.
OTHER INFORMATION YOU SHOULD KNOW

Plan Administration

The Company has entered into an Administrative Services Only (ASO) Agreement with the Claims Administrator, BlueCross BlueShield of Texas. The Plan Administrator has given the Claim Administrator the final authority and discretion to interpret the Health Benefit Plan provisions and to make benefit determinations. The Plan Administrator has full and complete authority and discretion to interpret the eligibility provisions of the Health Benefit Plan and to make eligibility determinations. Such decisions shall be final and conclusive.

The Plan Administrator may delegate to other persons the responsibilities for performing ministerial duties in accordance with the terms of the Plan and may rely on information, data, statistics or analysis provided by these persons.

Cost/Funding

The Plan is a self-insured welfare benefit plan. This means that claims are not paid through insurance purchased from an insurance company. Contributions from the Company and Plan participants are used to pay participant claims and the operating expenses of the Plan. By adopting a self-insured plan, the Company is able to reduce Plan costs by avoiding certain costs associated with typical insurance plans, such as risk charges and insurance taxes.

The Plan Administrator, on behalf of the Plan, has contracted with the Claims Administrator to process claims under the Plan and provide certain other administrative services. The Claims Administrator is paid a fee to provide these services.

The Claims Administrator has no incentive to deny or delay claims — they are simply reimbursed for claims that are paid under the Plan. The decisions of the Claims Administrator will be final, conclusive and binding on all persons with respect to all issues and questions related to Plan claims.

The decisions of the Plan Administrator will be final, conclusive and binding on all persons with respect to all other issues and questions relating to the Plan.

Each year, the Plan’s financial experience is reviewed by looking at contributions paid into the Plan compared to claims paid plus operating expenses. Based on this actuarial analysis (including projections of future medical costs), the Company may adjust contribution rates. Normally, any change in contributions will become effective on January 1.

Company Contributions

The amount of the Company’s contribution toward the cost of benefits under the Plan will be reviewed periodically, and any increase or decrease will be based on several factors, including the Company’s ability to continue making such contributions.

The Company reserves the right to suspend or discontinue these contributions at any time.

Participant Contributions

All Plan participants are required to share in the cost of the Plan. Contribution rates are published annually during the open enrollment period.

For active employees, your contributions for coverage are calculated on a daily pro-rata basis and will be deducted from your regular paycheck for the number of days of coverage received during the pay period.
As an active employee, your contributions will generally be paid on a “pre-tax basis,” which means:

- your contributions are deducted from your pay before taxes are withheld;
- you are not required to pay federal income tax and, in most cases, state and local taxes on the amount of this deduction; and
- you will pay less FICA Hospital Insurance taxes, and if you are earning less than the maximum taxable wage base for Old Age and Survivors Disability Insurance (“OASDI”) Social Security, you will also pay less OASDI Social Security taxes.

If you are on a leave of absence without pay or otherwise not receiving payroll compensation from the Company, please see If You Take a Leave of Absence.

If you drop any dependent’s coverage within 31 days of the dependent’s loss of eligibility and this changes your level of coverage and monthly contribution amount, you may be entitled to a refund.

- If you fail to drop coverage for your dependent within 31 days of the loss of eligibility, you will not be entitled to a refund of contributions, and the premium will not be reduced until the following Plan Year.
- The Claims Administrator will require reimbursement for any expenses paid after the retroactive loss of coverage date (unless otherwise prohibited under the Patient Protection and Affordable Care Act).

Future of the Plan

The Medical Plan is a voluntary plan. It is the Company’s intention to continue to provide benefits to participants of the Plan. However, the Company reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time and for any reason, including but not limited to, discontinuing Company contributions and/or retiree benefits. Such actions will be effective as of any date designated by the Company.

Changes to the Plan, if any, will be applied to all Plan participants as of the effective date of the change.

General Provisions

Type of Coverage

Coverage under the Plan is non-occupational — only non-occupational illnesses and accidental injuries are covered. Charges for services and supplies are covered only while the person is an eligible participant in the Plan.

Physical Examinations

BCBSTX has the right to examine and evaluate any person who submits a claim at all reasonable times while a claim is pending or under review. There is no cost to you for any such examination.

Legal Action

Legal action to pursue a benefit must be taken within three years from the date participation in the Plan ends or, if earlier, the date the claim is denied following exhaustion of the appeal procedures under the Plan.

Assignments

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided. In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan’s responsibility to the Employee or Dependents for benefits available under the Plan.

Waiver

BCBSTX’s failure to implement or insist upon compliance with any provision of the Plan contract at a given time shall not be interpreted as a waiver of BCBSTX’s right to implement or insist upon compliance with that provision at another time. This includes, but is not limited to, the payment of premiums and applies whether or not the circumstances are the same.
ADDITIONAL INFORMATION

As a participant or beneficiary under this Plan, you have certain rights and protections as more fully described in Your Rights Under ERISA. Other important information about the Plan is provided below:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>The Andeavor Medical Plan (a constituent benefit program of the Andeavor Omnibus Group Welfare Benefits Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Plan</td>
<td>Welfare Benefit Plan</td>
</tr>
<tr>
<td>Plan Sponsor</td>
<td>Andeavor 19100 Ridgewood Parkway San Antonio, TX 78259 (210) 828-8484</td>
</tr>
<tr>
<td>Plan Sponsor’s Employer Identification Number</td>
<td>95-0862768</td>
</tr>
<tr>
<td>Plan Administrator</td>
<td>Andeavor Employee Benefits Committee 19100 Ridgewood Parkway San Antonio, TX 78259 (866) 688-5465, press options 3, then option 5</td>
</tr>
<tr>
<td>Plan Number</td>
<td>501</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 – December 31</td>
</tr>
<tr>
<td>Plan Funding</td>
<td>The Plan is funded by employee and employer contributions.</td>
</tr>
<tr>
<td>Type of Administration</td>
<td>Administrative Service Only (ASO) contract with the Claims Administrator.</td>
</tr>
<tr>
<td>Claims Administrator</td>
<td>BlueCross BlueShield of Texas</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 660044</td>
</tr>
<tr>
<td></td>
<td>Dallas, TX 75266-0044</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.bcbstx.com">www.bcbstx.com</a></td>
</tr>
<tr>
<td></td>
<td>(800) 521-2227</td>
</tr>
<tr>
<td>Agent for Service of Legal Process</td>
<td>General Counsel Andeavor</td>
</tr>
<tr>
<td></td>
<td>19100 Ridgewood Parkway, San Antonio, TX 78259</td>
</tr>
<tr>
<td></td>
<td>In addition, service of legal process may be made upon the Plan Administrator.</td>
</tr>
</tbody>
</table>
YOUR RIGHTS UNDER ERISA

Under the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Company is required to provide you with the following statement of ERISA rights to fully inform you of your rights as a participant under those benefit plans subject to ERISA. As a participant in the Plan, you are entitled to certain rights and protections under ERISA.

Right to Receive Information About Your Plan and Benefits

ERISA provides that all Plan participants shall be entitled to:

• Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).

• Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500) and an updated Summary Plan Description. The Plan Administrator may charge a reasonable amount for the copies.

• Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

• Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce those rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court (providing you have first exhausted all claims and appeals procedures under the Plan). In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.
Assistance With Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

If you have any questions about the information presented here, please contact the Andeavor Benefit Center or your local HR Manager (see Contacts).

Rights of States Where Eligible Employees or Dependents are also Eligible for Medicaid Benefits

Compliance by the Plan with Assignment of Rights

Benefit payments with respect to a covered eligible employee or dependent who is also covered by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) — referred to in this section as a state’s Medicaid program — will be made in accordance with any assignment of rights made by or on behalf of the covered person as required by a state Medicaid program.

Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility

With respect to enrollment in the Plan or the payment of benefits under the Plan, the Plan will not take into account the fact that a covered person is also eligible for or qualifies for medical assistance under a state Medicaid program.

Acquisition by States of Rights of Third Parties (State Subrogation Rights)

The Plan will honor any subrogation rights that a state may have gained from a covered person eligible for Medicaid by virtue of the state’s having paid Medicaid benefits for which the Plan has a legal liability for covering.
REQUIRED WRITTEN NOTICE OF CURRENT BENEFITS

Two pieces of legislation apply to self-insured group health plans that are governed under ERISA:

- Women’s Health and Cancer Rights Act of 1998
- Newborns’ and Mothers’ Health Protection Act of 1996

These amendments represent benefits that were already provided under the Plan.

Women’s Health and Cancer Rights Act of 1998

The Plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and for complications resulting from a mastectomy, including lymphedemas.

If you elect breast reconstruction in connection with a mastectomy, coverage will be provided in a manner determined in consultation with you and your physician for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedemas.

These benefits are subject to all terms of the Plan, including relevant deductibles, coinsurance and out-of-pocket provisions applicable to other medical and surgical benefits provided under the Plan.

Newborns’ and Mothers’ Health Protection Act of 1996

The Newborns’ and Mothers’ Health Protection Act of 1996 (the Newborns’ Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

This section incorporates the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended, and the regulations issued thereunder as set forth in 45 C.F.R. Parts 160, 162 and 164, as amended (HIPAA Regulations).

Definitions

For purposes of this section, words and phrases not otherwise defined herein that are defined in the HIPAA Regulations shall have the meanings assigned therein when used herein. In the event of a conflict between the meaning of a word or phrase used herein with the definition given elsewhere in the Plan, the meaning given in this section shall control.

The Use and Disclosure of Protected Health Information

Effective April 14, 2003, the Plan will use and disclose protected health information without an authorization from the individual only to the extent of and in accordance with the uses and disclosures permitted by HIPAA and the HIPAA Regulations, including the following uses and disclosures:

• **Health care payment:** For this purpose, health care payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of benefits under the Plan or to obtain or to provide reimbursement for the provisions of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:
  – determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of benefit claims;
  – risk adjusting amounts due based on enrollee health status and demographic characteristics;
  – billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss coverage) and related health care data processing;
  – review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
  – utilization review activities, including pre-certification and preauthorization of services, concurrent and retrospective review of services; and
  – disclosures to consumer reporting agencies of any of the following protected health information relating to collection or premiums or reimbursement: name and address, date of birth, social security number, payment history, account number and name and address of health care provider and/or health plan.

• **Health care operations:** For this purpose, health care operations include, but are not limited to, the following activities:
  – conducting quality assessment and improvement activities, including outcomes and evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;
  – conducting population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;
  – reviewing the competence or qualifications of health care professionals, evaluation practitioner and provider performance, health plan performance, conducting training programs that students, trainees or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-healthcare professionals, accreditation, certification, licensing or credentialing activities;
  – underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance) provided certain requirements are met if applicable;
  – conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance review programs;
– business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

– business management and general administrative activities of the Plan, including, but not limited to:

(a) management activities relating to the implementation of and compliance with HIPAA’s administrative simplification requirements;
(b) customer service, including the provision of data analyses for policyholders, Plan Sponsors or other customers, provided the protected health information is not disclosed to such policy holder, Plan Sponsor or customer;
(c) resolution of internal grievances;
(d) the sale, transfer, merger or consolidation of all or part of the Plan with another Plan, or an entity that following such activity will become a covered entity and due diligence related to such activity; and/or transfer of assets to a potential successor in interest; and
(e) consistent with the applicable requirements of 45 C.F.R. § 164.514, creating de-identified health information or a limited data set, and fundraising for the benefit of the Plan.

• Treatment: For this purpose, treatment means:
  – the provision, coordination or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party;
  – consultation between health care providers relating to a patient; or
  – the referral of a patient for health care from one health care provider to another.

Disclosure to the Plan Sponsor

The Plan will disclose protected health information to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the requirements listed under the headings Additional Agreements of Plan Sponsor and Adequate Separation Between the Plan and the Plan Sponsor below. The Plan has received this certification from the Plan Sponsor. Note, however, that protected health information disclosed to the Plan Sponsor can be used only for Plan administrative functions performed by the Plan Sponsor.

However, the Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending or terminating the Plan. In addition, the Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

The Plan participates in an organized health care arrangement with the following plan sponsored by the Plan Sponsor: The Andeavor Omnibus Group Welfare Benefits Plan. Accordingly, the Plan and such plan may exchange protected health information for treatment, payment and health care operations purposes of such organized health care arrangement.

Additional Agreements of Plan Sponsor

With respect to protected health information, the Plan Sponsor further agrees to:

• not use or further disclose the information other than as permitted or required by the Plan document or as required by law;
• ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
• not use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
• report to the Plan any protected health information use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
• make available protected health information to an individual in accordance with HIPAA’s access requirements and 45 C.F.R. § 164.524;
• make available protected health information for amendment and incorporate any amendments to protected health information in accordance with HIPAA and 45 C.F.R. § 164.526;
• make available the information required to provide an accounting of disclosures in accordance with HIPAA and 45 C.F.R. § 164.528;
• make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the Department of Health and Human Services for the purposes of determining the Plan’s compliance with HIPAA;
• if feasible, return or destroy all protected health information received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible;
• ensure that adequate separation between the Plan and Plan Sponsor (as described below) is established;
• effective April 20, 2005, implement administrative, physical and technological safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Plan (except with respect to enrollment and disenrollment information, summary health information and protected health information disclosed pursuant to an authorization under 45 C.F.R. § 164.508) and shall ensure that any agents (including subcontractors) to whom it provides such electronic protected health information agree to implement reasonable and appropriate security measures to protect such information; and
• effective April 20, 2005, report to the Plan any security incident of which it becomes aware.

Adequate Separation Between the Plan and the Plan Sponsor

In accordance with HIPAA and the HIPAA Regulations, only the following employees or classes of employees or other persons may be given access to protected health information to be disclosed:
• the Plan Administrator;
• Human Resources employees within the Andeavor Benefit Center;
• Human Resources employees with responsibility for investigating appeals and recommending decisions to the Plan Administrator;
• Human Resources employees with access to the data that is stored electronically;
• employees within the Information Technology (“IT”) Group that maintain the servers on which some protected health information may be stored;
• employees in the Controller’s Department who handle benefits accounting or payroll;
• employees in the Internal Audit Department; and
• in-house legal counsel.

The persons identified in this sub-section may only have access to and use and disclose protected health information for Plan administration functions that the Plan Sponsor performs for the Plan. If the persons identified in this section do not comply with the restrictions set forth in this Plan document and otherwise under HIPAA and the HIPAA Regulations, the Plan Sponsor shall respond to such noncompliance in accordance with the requirements of applicable law and the Plan Sponsor’s policies, including as appropriate, the imposition of disciplinary sanctions. The Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic protected health information.

Consistency With HIPAA and HIPAA Regulations

In the event any amendment to HIPAA or the HIPAA Regulations is adopted that renders any provision of this section inconsistent therewith, this section shall be deemed amended to be consistent therewith.
Other Uses and Disclosures of Health Information

In addition to the above uses and disclosures, the Plan Sponsor may use and disclose protected health information to the fullest extent permitted under HIPAA or the HIPAA Regulations.

Notice of Privacy Practices

The HIPAA Regulations require the Plan to provide you with a notice describing the Plan’s privacy practices and other information regarding your privacy rights with respect to protected health information. This notice is provided at the time of enrollment to new Plan enrollees. In addition, an updated notice will be provided to all Plan participants within 60 days of any material revision of the notice. Copies of the notice are available at all times through the Andeavor Benefit Center.

CONTACTS

The following contacts are available to answer questions and provide information about the Plan.

Andeavor Benefits Center
P.O. Box 3129
Bellaire, TX 77402
www.tsocorp.com/benefits
(866) 787-6314

Andeavor Corporate Benefits Department
19100 Ridgewood Parkway
San Antonio, TX 78259
Email: SAT – Benefits Department (satbenefits@tsocorp.com)
(866) 688-5465

Claims Administrator

Medical and Prescription Drugs:

BlueCross BlueShield of Texas
P.O. Box 660044
Dallas, TX 75266-0044
www.bcbstx.com
(800) 521-2227
GLOSSARY

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

**Acquired Brain Injury** means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

**Allowable Amount** means the maximum amount determined by the Claim Administrator (BCBSTX) to be eligible for consideration of payment for a particular service, supply, or procedure.

- For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claim Administrator in Texas or any other Blue Cross and Blue Shield Plan – The contracting Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

- For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with the Claim Administrator in Texas or any other Blue Cross and Blue Shield Plan – The non-contracting Allowable Amount will be the lesser of: (i) the Provider’s billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 300% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 75% and shall be updated on a periodic basis.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by the Claim Administrator. Such factor shall be not less than 300% and shall be updated not less than every two years.

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

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

The non-contracting Allowable Amount does not equate to the Provider’s billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider’s billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back of your BCBSTX Identification Card.
• **For multiple surgeries** - The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

• For procedures, services, or supplies provided to Medicare recipients - The Allowable Amount will not exceed Medicare’s limiting charge.

• **For Covered Drugs as applied to Participating and non-Participating Pharmacies** - The Allowable Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between the Claim Administrator and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service. The Allowable Amount for non-Participating Pharmacies will be based on the Average Wholesale Price.

**Ambulance** means a vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

**Average Wholesale Price** means any one of the recognized published averages of the prices charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

**Behavioral Health Practitioner** means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency.

**Body Mass Index** means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

**Brand Name Prescription Drug** means a prescription drug with a proprietary name assigned to it by the manufacturer or distributor.

**Calendar Year** means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

**Certain Diagnostic Procedures** means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)

**Chemical Dependency** means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

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

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

**Chiropractic Services** means any of the following services, supplies or treatment provided by or under the direction of a Doctor of Chiropractic acting within the scope of his license: general office services, general services provided in an outpatient facility setting, x-rays, supplies, and physical treatment. Physical treatment includes functional occupational therapy, physical/mechano therapy, muscle manipulation therapy and hydrotherapy.
Claim Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claim Administrator, may subcontract portions of its responsibilities.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:
- Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
- Urine auto injection (injecting one’s own urine into the tissue of the body);
- Skin irritation by Rinkel method;
- Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
- Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

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

Coinsurance is both the percentage of covered expenses that the Plan pays and the percentage of covered expenses that you pay. The percentage that the Plan pays is referred to as the “plan coinsurance” and varies by the type of expense. Please refer to the Medical Plan Summary Chart for specific information on coinsurance amounts.

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

Co-share Amount means the dollar amount of Eligible Expenses including Deductible(s) and Copayment Amounts incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:
- Can be expected or is intended to improve the physical appearance of a Participant; or
- Is performed for psychological purposes; or
- Restores form but does not correct or materially restore a bodily function.

Covered Expenses are medical, dental, vision or hearing services and supplies shown as covered under this SPD and the plan documents.
Covered Oral Surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
- Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology;
- Incision and drainage of facial abscess; and
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Creditable Coverage means a person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Such coverage includes:

- health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- health care for members of the uniformed services;
- a program of the Indian Health Service;
- a state health benefits risk pool;
- the Federal Employees’ Health Benefit Plan (FEHBP);
- a public health plan (any plan established by a state, the government of the United States or any subdivision of a state or of the government of the United States, or a foreign country);
- any health benefit plan under Section 5(e) of the Peace Corps Act; and
- the State Children’s Health Insurance Program (S-CHIP).

Crisis Stabilization Unit or Facility means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. Custodial Care is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.

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

Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material) regarding:

- Diet;
- Regulation or management of diet; or
- The assessment or management of nutrition.
**Durable Medical and Surgical Equipment (DME)** means equipment and the accessories needed to operate it, which is:
- made to withstand prolonged use;
- made for and mainly used in the treatment of an illness or injury;
- suited for use in the home;
- not normally of use to persons who do not have an illness or injury;
- not for use in altering air quality or temperature; and
- not for exercise or training.

**Durable Medical Equipment Provider** means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

**Eligible Expenses** mean Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, Special Provisions Expenses, and pharmacy expenses as described in this SPD and the plan documents.

**Emergency Care** means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person’s condition, sickness, or injury is of such a nature that failure to get immediate care could result in:
- placing the patient’s health in serious jeopardy;
- serious impairment of bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

**Environmental Sensitivity** means the inpatient or outpatient treatment of allergic symptoms by:
- Controlled environment; or
- Sanitizing the surroundings, removal of toxic materials; or
- Use of special non-organic, non-repetitive diet techniques.

**Experimental/Investigational** means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as standard medical treatment of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, medical treatment includes medical, surgical, or dental treatment. Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:
- have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
- are appropriate for the Hospital or Facility Other Provider in which they were performed; and
- the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The Claim Administrator for the Plan shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government-financed programs in making its determination. Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Claim Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.
Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the Extended Care Expenses portion of the plan document.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Generic Prescription Drug means a prescription drug, whether identified by its chemical, proprietary or non-proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

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

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Homebound means when you are confined to your place of residence due to an illness or injury that makes leaving the home medically contraindicated, or because the act of transport would be a serious risk to your life or health.

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

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

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

Home Infusion Therapy shall include:

- Drugs and IV solutions;
- Pharmacy compounding and dispensing services;
- All equipment and ancillary supplies necessitated by the defined therapy;
- Delivery services;
- Patient and family education; and
- Nursing services.

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

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

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

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

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.
Hospital means a short-term acute care facility which:

- Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or Behavioral Health Practitioners for compensation from its patients;
- Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
- Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
- Has in effect a Hospital Utilization Review Plan; and
- Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a Bed patient and the time of discontinuance of bed-patient care or discharge by the admitting Physician, Behavioral Health Practitioner or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a Bed patient in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Claim Administrator. Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long-term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Claim Administrator of the Plan indicating pertinent information applicable to his coverage.

Illness means a pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License.

Independent Laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

Infertile or Infertility means the condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- for a woman who is under 35 years of age, one year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- for a woman who is 35 years of age or older, six months or more of timed, unprotected coitus, or six cycles of artificial insemination.

Injury means an accidental bodily injury that is the sole and direct result of:

- an unexpected or reasonably unforeseen occurrence or event; or
- the reasonable unforeseeable consequences of a voluntary act by the person.

The act or event must be definite as to time and place.
In-Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out-of-Network Provider when acknowledged by the Claim Administrator.

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

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

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

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

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

Jaw Joint Disorder means any of the following:

• a Temporomandibular Joint (TMJ) dysfunction or any similar disorder of the jaw joint;
• a Myofacial Pain Dysfunction (MPD); or
• any similar disorder in the relationship between the jaw joint and the related muscles and nerves.

Late Enrollee means an employee in an eligible class who requests enrollment under this Plan after the initial enrollment period. In addition, this is an eligible dependent for whom the employee did not elect coverage within the initial enrollment period, but for whom coverage is elected at a later time. However, an eligible participant may not be considered a Late Enrollee under certain circumstances.

L.P.N. means a licensed practical or vocational nurse.

Mail-Order Pharmacy means an establishment where prescription drugs are legally dispensed by mail or other carrier.

Maintenance Care means care made up of services and supplies that:

• are furnished mainly to maintain, rather than to improve, a level of physical or mental function; and
• provide a surrounding free from exposures that can worsen the person’s physical or mental condition.

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

Maternity Care means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.
Medical Social Services means those social services relating to the treatment of a Participant’s medical condition. Such services include, but are not limited to assessment of the:

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

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

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

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

- Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
- Billed to the patient by the directing Physician, Behavioral Health Practitioner or Professional Other Provider. An expense shall have been incurred on the date of provision of the service for which the charge is made.

Medically Necessary or Medical Necessity means those services or supplies covered under the Plan which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant.

When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant’s condition, and the Participant cannot receive safe or adequate care as an outpatient.

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

Medicare Part D means the voluntary prescription drug benefit offered under Medicare starting on January 1, 2006. Individuals entitled to Medicare Part A and/or enrolled in Part B are eligible for Part D. The average monthly premium varies by region or plan. The standard benefit in 2017 will pay a percentage of your drug costs (varies by plan) after a $400 deductible, up to an initial coverage limit of $3,700, and will pay 95% of drug costs once the Medicare member spends $4,950 out-of-pocket.
Mental Health Care means any one or more of the following:

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

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter\(^2\) or a BMI greater than or equal to 35 kg/meter\(^2\) with at least two of the following co-morbid conditions which have not responded to a maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:

- Hypertension
- Dyslipidemia
- Type 2 diabetes
- Coronary heart disease
- Sleep Apnea

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

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

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

Non-Occupational Illness means a non-occupational illness is an illness that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an illness that does. An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person is covered under any type of workers’ compensation law and is not covered for that illness under such law.

Non-Occupational Injury means a non-occupational injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, or result in any way from an injury that does.

Non-Urgent Admission means an inpatient admission that is not an emergency admission or an urgent admission.
**Occupational Injury or Occupational Illness** means an injury or illness that arises out of (or in the course of) any activity in connection with employment or self-employment, whether or not on a full-time basis, or results in any way from an injury or illness that does.

**Occurrence** means a period of disease or injury. An occurrence ends when 60 consecutive days have passed during which the covered person receives no medical treatment, services or supplies for a disease or injury and neither takes any medication, nor has any medication prescribed, for a disease or injury.

**Orthodontic Treatment** means any medical or dental service or supply furnished to prevent, diagnose or correct a misalignment of the teeth, bite, jaws or jaw joint relationship, whether or not for the purpose of relieving pain. Not included is the installation of a space maintainer or a surgical procedure to correct malocclusion.

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

- **Facility Other Provider** means an institution or entity, only as listed:
  - Birthing Center
  - Chemical Dependency Treatment Center
  - Crisis Stabilization Unit or Facility
  - Durable Medical Equipment Provider
  - Home Health Agency
  - Home Infusion Therapy Provider
  - Hospice
  - Imaging Center
  - Independent Laboratory
  - Prosthetics/Orthotics Provider
  - Psychiatric Day Treatment Facility
  - Renal Dialysis Center
  - Residential Treatment Center for Children and Adolescents
  - Skilled Nursing Facility
  - Therapeutic Center

- **Professional Other Provider** means a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
  - Advanced Practice Nurse
  - Doctor of Chiropractic
  - Doctor of Dentistry
  - Doctor of Optometry
  - Doctor of Podiatry
  - Doctor in Psychology
  - Licensed Acupuncturist
  - Licensed Audiologist
  - Licensed Chemical Dependency Counselor
  - Licensed Dietitian
  - Licensed Hearing Instrument Fitter and Dispenser
  - Licensed Marriage and Family Therapist
  - Licensed Clinical Social Worker
  - Licensed Occupational Therapist
  - Licensed Physical Therapist
  - Licensed Professional Counselor
  - Licensed Speech-Language Pathologist
  - Licensed Surgical Assistant
  - Nurse First Assistant
  - Physician Assistant
  - Psychological Associates who work under the supervision of a Doctor in Psychology In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.
Out-of-Area Benefits means the benefits available under the Plan for services and supplies that are provided when a Participant resides outside of the Managed Care Plan Service Area and therefore does not have access to Network Providers.

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

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

Out-of-Pocket Maximum means a provision designed to limit the amount of covered expenses you must pay each year. Your deductibles, coinsurance and other eligible out-of-pocket expenses apply to the out-of-pocket maximum. Once you satisfy the maximum amount, the Plan will pay 100% of covered expenses that apply toward the maximum for the rest of the calendar year. Some of the Plan options have separate out-of-pocket maximums for network and out-of-network services.

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

Participant means an Employee or Dependent or a retired Employee whose coverage has become effective under this Plan.

Pharmacy means an establishment where prescription drugs are legally dispensed. Pharmacy includes retail pharmacy, mail-order pharmacy or specialty pharmacy.

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

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

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

Preferred Drug List means a listing of prescription drugs established by BCBSTX which includes both brand name prescription drugs and generic prescription drugs currently covered by the plan.

Prescription Drug means a drug, biological or compounded prescription that, by state and federal law, may be dispensed only by prescription and that is required to be labeled “Caution: Federal Law prohibits dispensing without prescription.”

Primary Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Proof of Loss means written evidence of a claim including:
- The form on which the claim is made;
- Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
- Correct diagnosis code(s) and procedure code(s) for the services and items.
**Prosthetic Appliances** means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

**Prosthetics/Orthotics Provider** means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies. Provider means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Participant an item of service or supply listed as Eligible Expenses.

**Psychiatric Day Treatment Facility** means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician or Behavioral Health Practitioner to be in lieu of hospitalization.

**Psychiatric Physician** means a physician who specializes in psychiatry or has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or mental disorders.

**QMCSO** means a Qualified Medical Child Support Order.

**Rehabilitation Facility** means a facility, or a distinct part of a facility, that:
- provides rehabilitative services;
- meets any licensing or certification standards established by the jurisdiction where it is located; and
- makes charges for its services.

**Renal Dialysis Center** means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

**Residential Treatment Center for Children and Adolescents** means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

**Retail Health Clinic** means a facility that provides treatment of uncomplicated minor illnesses. Retail Health Clinics are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

**R.N.** means a registered nurse.

**Room and Board** means charges made by an institution for room and board and other medically necessary services and supplies.

**Self-injectable Drug(s)** means prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

**Serious Mental Illness** means the following psychiatric illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):
- Bipolar disorders (hypomanic, manic, depressive, and mixed);
- Depression in childhood and adolescence;
- Major depressive disorders (single episode or recurrent);
- Obsessive-compulsive disorders;
- Paranoid and other psychotic disorders;
- Schizo-affective disorders (bipolar or depressive); and
• Schizophrenia.

**Skilled Nursing Facility** means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

• Licensed in accordance with state law (where the state law provides for licensing of such facility); or
• Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

**Specialty Care** means health care services or supplies that require the services of a specialist.

**Specialty Care Provider** means a Physician or Professional Other Provider who has entered into an agreement with Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services with the exception of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

**Stay** means a full-time inpatient confinement for which a room and board charge is made.

**Substance Abuse** means a physical or psychological dependency, or both, on a controlled substance or alcohol agent. (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, which is current as of the date services are rendered to you or your insured dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM), an addiction to nicotine products, food or caffeine intoxication.

**Surgery Center** means a freestanding ambulatory surgical facility.

**Telehealth Service** means a health service, other than a Telemedicine Medical Service, delivered by a licensed or certified health professional Provider acting within the scope of the health care professional Provider’s license or certification who does not perform a Telemedicine Medical Service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

• Compressed digital interactive video, audio, or data transmission;
• Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
• Other technology that facilitates access to health care services or medical specialty expertise.

**Telemedicine Medical Service** means a health care service initiated by a Physician or Behavioral Health Practitioner or provided by a health professional Provider acting under Physician or Behavioral Health Practitioner delegation and supervision for purposes of patient assessment by a health professional, diagnosis, or consultation by a Physician or Behavioral Health Practitioner, treatment or the transfer of medical data that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

• Compressed digital interactive video, audio or data transmission;
• Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
• Other technology that facilitates access to health care services or medical specialty expertise.

**Terminally Ill (Hospice Care)** means a medical prognosis of six months or less to live.

**Therapeutic Center** means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

• An ambulatory (day) surgery facility;
• A freestanding radiation therapy center; or
• A freestanding birthing center.
**Therapeutic Drug Class** means a group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or injury.

**Urgent Care or Walk-in Clinic** means freestanding health care facilities. They are an alternative to a physician’s office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room nor the outpatient department of a hospital shall be considered an urgent care or walk-in clinic.

**USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

**Waiting Period** means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

**WHCRA** means the Women’s Health and Cancer Rights Act of 1998, as amended.