

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

**SELECTEMP® PPO**

**Single Term, Non-Renewable Short Term Policy**  
**Preferred Provider Plan providing**

**Comprehensive Major Medical Coverage**

**REQUIRED OUTLINE OF COVERAGE**

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

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

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

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

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

**A. Benefit Period** — The Benefit Period begins on the Effective Date of your coverage under this Contract and ends on the expiration date. The length of your Contract is \_\_\_\_\_ months.

**B. Effective Date** — Coverage under this Contract shall begin at 12:01 a.m. on the later of:

1. A future requested Effective Date; or
2. The day after the postmark day affixed by the U.S. Post Office.

If the envelope containing the application is not postmarked by the U. S. Post Office or the postmark is not legible, the Effective Date will be the later of (a) the requested Effective Date, or (b) the date We receive the application.

Coverage will end on the same day of the month as the Effective Date. For example, if you choose a three-month coverage period and you request an effective date of September 5th, the Contract will expire at 11:59 p.m. on December 4th. Note: If coverage begins on the 31st day of the month, it will end on the last day of any shorter month, if applicable. (e.g. January 31st to April 30th).

**C. Deductibles** — The Benefit Period Deductible will be subtracted once during each Benefit Period from each Participant's total Eligible Expense. The family Deductible is three times the individual Deductible amount. No Participant will be required to satisfy more than the individual Deductible amount toward the family Deductible amount. The amount of Your Deductibles will be as selected below:

Options	Network Deductibles		Out-of-Network Deductibles	
	Individual	Family	Individual	Family
Plan I <input type="checkbox"/>	\$500	\$1,500	\$1,000	\$3,000
Plan II <input type="checkbox"/>	\$1,000	\$3,000	\$2,000	\$6,000
Plan III <input type="checkbox"/>	\$1,500	\$4,500	\$3,000	\$9,000
Plan IV <input type="checkbox"/>	\$2,000	\$6,000	\$4,000	\$12,000
Plan V <input type="checkbox"/>	\$2,500	\$7,500	\$5,000	\$15,000

D. **Copayment Amount** — The Copayment Amount will be required for each emergency room visit.

Options	Network Copayment Amount	Out-of-Network Copayment Amounts
<i>Applicable to all Plans</i> Emergency room facility visit*	\$100	\$100

\*Waived if admitted to Hospital immediately following the visit. (This Copayment Amount applies to the facility visit only. The facility and Physician services and supplies are subject to the Deductible and Coinsurance Amount.)

E. **Preauthorization** — Preauthorization is required for all Hospital Admissions and Home Infusion Therapy. You, Your Physician or Professional Other Provider or a family member must call the toll-free telephone number listed on the back of the Identification Card.

When a Hospital Admission is preauthorized, a length-of-stay is assigned. This Contract provides a minimum length-of-stay in a Hospital for the treatment of breast cancer of (1) 48 hours following a mastectomy, and (2) 24 hours following a lymph node dissection.

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

F. **Eligible Expenses** — After the applicable Deductible(s) and Copayment Amounts, if any, are met, Your coverage pays 80% of the Allowable Amount for Eligible Expenses provided by a Network Provider and 60% of the Allowable Amount for Eligible Expenses rendered by an Out-of-Network Provider, subject to other provisions of the Contract. The remainder of these Eligible Expenses becomes “Coinsurance Amounts” and must be paid by You.

<b>IMPORTANT TO YOUR COVERAGE</b>		
<p>To pay less out-of-pocket expenses and to receive the higher level of benefits for your health care costs, it is to your advantage to use Network Providers. If you use Network Providers, you will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much you would pay if you use a Network Provider and how much you would pay if you use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same:</p>		
<b>EXAMPLE ONLY</b>		
	<b>In-Network</b> 80% of eligible charges \$250 Deductible	<b>Out-of-Network</b> 60% of eligible charges \$500 Deductible
Amount Billed	\$20,000	\$20,000
Allowable Amount	\$5,000	\$5,000
Deductible Amount	\$250	\$500
Plan’s Coinsurance Amount	\$3,800	\$2,700
Your Coinsurance Amount	\$950	\$1,800
Non-Contracting Provider’s additional charge to you	None	\$15,000 <sup>1</sup>
<b>YOUR TOTAL PAYMENT</b>	<b>\$1,200</b> to a Network Provider	<b>\$17,300<sup>1</sup></b> to a Non-contracting Out-of-Network Provider
<p>Even when you consult a Network Provider, ask questions about any of the Providers rendering care to you. For example, if you are scheduled for surgery, ensure that your Network surgeon will be using a Network facility for your procedure and a Network Provider for your anesthesia services.</p>		
<p><sup>1</sup>If you choose to receive services from an Out-of-Network Provider, inquire if he participates in a contractual arrangement with BCBCTX. Providers who do not contract with BCBSTX or any other Blue Cross and Blue Shield plan will bill the patient for expenses over the Allowable Amount. Please refer to the section entitled <i>PARPLAN</i> in the Contract.</p>		

1. ***Inpatient Hospital Expense:***
  - a. For a preauthorized Hospital Admission, room and board charges. If You stay in a private room, only the Hospital's average semi-private room rate will be considered for benefits.
  - b. Intensive care and coronary care units.
  - c. All other usual Hospital services.
  
2. ***Medical-Surgical Expense:***
  - Services of Physicians, Professional Other Providers, and certified registered nurse-anesthetists (CRNA).
  - Physical Medicine Services (therapies), up to a maximum benefit of \$500 for each Participant each Benefit Period.
  - Diagnostic x-ray, laboratory procedures, and radiation therapy.
  - Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
  - Rental of durable medical equipment (DME) required for therapeutic use (does not include such items as air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment).
  - Professional local ground or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition will be provided at the Network Benefits level, up to a maximum benefit amount of \$750 per Participant each Benefit Period.
  - Anesthetics and administration when performed by someone other than the operating Physician or Professional Other Provider.
  - Oxygen and its administration provided the oxygen is used.
  - Blood, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for the Participant.
  - Prosthetic Appliances, excluding all replacements of such devices other than those required by growth to maturity of the Participant.
  - Orthopedic braces and crutches.
  - Home Infusion Therapy.
  - Services or supplies received during an outpatient visit to a Hospital.
  - Diabetic Equipment and Supplies as provided in the Contract.
  - Outpatient Contraceptive Services and prescription contraceptive devices. However, prescription oral contraceptive medications are provided under the Prescription Drug Program.
  - Telehealth Services and Telemedicine Medical Services.

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

3. **Childhood Immunizations** — Childhood immunizations are available for a Dependent child from birth to age 8 at 100% of the Allowable Amount for Network and Out-of-Network Benefits. The Deductible and Coinsurance Amount will not apply.
  
4. **Newborn Screening Tests for Hearing Impairment** — Screening tests for hearing loss from birth through the date the Dependent child is 30 days old; and necessary diagnostic follow-up care related to the screening test from birth through the date the Dependent child is 24 months old. The Deductible does not apply; however benefits will be subject to all other contractual provisions.
  
5. **Benefits for Routine Mammography Screening** — Benefits are provided for female Participants 35 years of age or for a routine screening by low-dose mammography for the presence of occult breast cancer except that benefits will not be available for more than one routine mammography screening each Benefit Period.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after Benefit Period Deductible	60% of the Allowable Amount after Benefit Period Deductible

*Non-routine diagnostic mammograms are provided at 80% of the Allowable Amount after Benefit Period Deductible for Network and 60% of the Allowable Amount after Benefit Period Deductible for Out-of-Network Benefits.*

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

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after Benefit Period Deductible	60% of the Allowable Amount after Benefit Period Deductible

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

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

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after Benefit Period Deductible	60% of the Allowable Amount after Benefit Period Deductible

8. **Benefits for Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer** — Benefits are provided to female Participants 18 years of age or older for an annual medically recognized diagnostic examination for the early detection of cervical cancer.

- A conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of human Papillomavirus.
- Such screening test must be performed in accordance with the guidelines adopted by:
  - (a) The American College of obstetricians and Gynecologists; or
  - (b) Another similar national organization of medical professionals.

Network Benefits	Out-of-Network Benefits
80% of the Allowable Amount after Benefit Period Deductible	60% of the Allowable Amount after Benefit Period Deductible

- F. **Coinsurance Amounts** — When a Participant’s Coinsurance Amounts for a Benefit Period equal the amount shown below, the benefit percentages change to 100% for the remainder of that Benefit Period. The family Coinsurance Amount is three times the individual Coinsurance Amount. No Participant will be allowed to satisfy more than the individual Coinsurance Amount toward the family Coinsurance Amount.

Options	Network Coinsurance Amount	Out-of-Network Coinsurance Amount
<i>Applicable to all Plans</i>		
Individual	\$1,000	\$3,000
Family	\$3,000	\$9,000

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

Covered Service	Network Benefits	Out of Network Benefits
<ul style="list-style-type: none"> <li>▪ <b>Accident &amp; Medical Emergency within 48 hours</b></li> <li>– Facility Charges</li> <li>– Physician Charges</li> </ul>	80% of Allowable Amount after \$100 Copayment Amount* and Benefit Period Deductible 80% of Allowable Amount after Benefit Period Deductible	
<ul style="list-style-type: none"> <li>▪ <b>Non-Emergency Situations</b></li> <li>– Facility Charges</li> <li>– Physician Charges</li> </ul>	80% of Allowable Amount after Benefit Period Deductible 80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible 60% of Allowable Amount after Benefit Period Deductible

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

- H. **Maximum Lifetime Benefits** — The lifetime maximum of a Participant’s benefits is \$2,000,000.

- I. **Prescription Drug Program, including Mail Service Prescription Drugs**

1. **Benefit Period Maximum** — There is a \$750 Benefit Period maximum for each Participant whether or not benefits are received at a Participating Pharmacy, Non-Participating Pharmacy or through the Mail Service Prescription Drug Program.
2. **Deductible/Copayment Amounts** — There is a separate \$200 Prescription Drug Deductible that must be satisfied before any benefits are available under the Contract. Once the Prescription Drug Deductible has been met the Prescription Drug Copayment Amount will apply. The applicable Copayment Amount will be based on whether Your prescription is filled at a Participating Pharmacy or through the Prescription Drug Mail Service.

<b>PRESCRIPTION DRUG PROGRAM</b>			
<b>PLAN FEATURES <i>Applicable to all Plans</i></b>			
<b>Benefit Period Deductible</b>	<b>\$200</b>		
<b>Benefit Period Maximum</b>	<b>\$750</b>		
<b>Copayment Amounts</b>	<b>Generic</b>	<b>Preferred Brand Name Drugs</b>	<b>Non-Preferred Brand Name Drugs</b>
<b>Retail Pharmacy</b>			
<ul style="list-style-type: none"> <li>▪ 30-Day Supply on each occasion dispensed</li> <li>▪ 90-Day Supply</li> </ul>	\$10 \$30	\$40 \$120	\$55 \$165
<b>Mail Service</b>			
<ul style="list-style-type: none"> <li>▪ 90-Day Supply</li> </ul>	\$20	\$80	\$110

\*Combined Benefit Period Maximum for retail and Mail Service.

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

- If Your Physician has marked the prescription order “Dispense as Written” (DAW), the pharmacist may only dispense the brand name drug and You pay the appropriate Copayment Amount.
- If Your Physician has not stipulated DAW, the Generic Drug will be dispensed unless You choose to purchase the brand name drug instead of the Generic Drug and if the brand name drug is dispensed:
  - Is on the Preferred Brand Name Drug List, You will pay the Preferred Brand Name Drug Copayment Amount *plus* the difference between the Generic Drug and the Preferred Brand Name Drug, or
  - Is a Non-Preferred Brand Name Drug, you pay *only* the Non-Preferred Brand Name Drug Copayment Amount.

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

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

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

#### **IV. Limitations and Exclusions – *Benefits of the medical portion of the Contract are not available for:***

- Preexisting Conditions.
- Maternity Care.
- Services or supplies not Medically Necessary for the treatment of a sickness, injury, condition, disease, or bodily malfunction; any Experimental/Investigational services and supplies.
- Any charges more than the Allowable Amount as determined by Us.
- Any services or supplies for which benefits are, or upon proper claim would be, provided under Workers' Compensation Law.
- Any services or supplies covered in whole or in part by any laws of the United States (including Medicare), a foreign country, state or political subdivision except for Medicaid.
- Charges for services and supplies provided which require Our approval when approval is not given.
- Services or supplies for which You are not required to make payment or for which You are not legally required to pay without this or any similar coverage, (except treatment of mental illness or mental retardation by a tax supported institution).
- Any services or supplies provided by a person who is related to You by blood or marriage.
- Treatment of injury or sickness because of war, acts of war, or while on active or reserve military duty.
- Any charges because of suicide or attempted suicide, while sane or insane.
- Charges resulting from failure to keep a scheduled visit with a Physician or Professional Other Provider, for completion of any insurance forms, or for acquisition of medical records.
- Room and board charges during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been done on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.

- Services or supplies provided during a Hospital Admission or an admission in a Facility Other Provider beginning before the patient's Effective Date, or services or supplies provided after the termination of the Participant's coverage, except as provided in the Contract.
- Dietary and nutritional services, **except** as may be provided in the Contract for (1) a nutritional assessment program provided in and by a Hospital and approved in advance by Us; (2) *Treatment of Diabetes*, and (3) *Certain Therapies for Children with Developmental Delay*.
- Custodial Care.
- Routine physical examinations (including a routine Pap smear), diagnostic screening, or immunizations, **except** as provided in the Contract for (1) *Mammography Screening*, (2) *Certain Tests for Detection of Human Papillomavirus and Cervical Cancer*; (3) *Childhood Immunizations*, (4) *Certain Tests for the Detection of Prostate Cancer*, and (5) *Newborn Screen Tests for Hearing Impairment*; (6) *Certain Tests for the Detection of Colorectal Cancer*; and (7) *Certain Therapies for Children with Developmental Delay*.
- Services or supplies (except Medically Necessary diagnostic and/or surgical procedures) for treatment of the jaw bone joints, muscles, or their related structures with oral appliances or splints, orthotics, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint (TMJ) and all adjacent or related muscles and nerves. to eliminate pain or dysfunction.
- Services or supplies provided to correct congenital, developmental or acquired deformities of the jaw bone after a Participant's 19th birthday.
- Any items of *Medical-Surgical Expense* provided for dental care and treatments, dental surgery, or dental appliances, except (1) Oral Surgery as defined in the Contract, and (2) services made necessary by Accidental Injury.
- Cosmetic, Reconstructive or Plastic Surgery unless caused by (1) Accidental Injury; (2) reconstructive surgery following cancer surgery; (3) reconstructive surgery following mastectomy; surgery and reconstruction of the other breast to achieve symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; and (4) reconstructive surgery performed on a 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 developmental deformities, trauma, tumors, infections, or disease.
- Refractive surgery, or eyeglasses, contact lenses or, hearing aids, or examinations for the prescription of them; or examinations for detecting visual sharpness or level of hearing.
- Mental, emotional or functional nervous disorders without demonstrable organic brain disease, except Organic Brain Disease as defined in the Contract.
- Except as specifically provided in the Contract, any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.
- Treatment of adolescent behavior disorders, including conduct disorders and oppositional disorders.
- Occupational therapy services that do not consist of traditional physical therapy modalities and is not part of a physical rehabilitation program.
- Travel, whether recommended by a Physician or Professional Other Provider, except ambulance services as provided in the Contract.
- Treatment of obesity or weight, including surgical procedures, even if other health conditions might be helped by the reduction.
- Any services or supplies for inpatient allergy testing, or any testing or treatment for environmental sensitivity or clinical ecology, or any treatment not recognized as safe and effective.
- Any services or supplies provided with chelation therapy, except treatment of acute metal poisoning.
- Any services or supplies for sterilization reversal (male or female), transsexual surgery, sexual dysfunction, in vitro fertilization services, or artificial insemination.
- Routine footcare as described in the Contract.

- Any Speech and Hearing Services except as provided in the Contract for (1) *Extended Care Expense*, (2) *Newborn Screening Tests For Hearing Impairment*; and (3) *Certain Therapies for Children With Developmental Delay*.
- Any services or supplies for reduction mammoplasty.
- Services or supplies for acupuncture, videofluoroscopy, intersegmental traction, surface EMGs, manipulation under anesthesia, and muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
- Services or supplies for treatment of Chemical Dependency; unless an acute life-threatening condition occurs, in which case benefits for Eligible Expenses incurred in a Hospital during the acute life-threatening stage only will be provided on the same basis as for any other sickness.
- Orthodontic or other dental appliances; splints or bandages provided by a Physician in a non-hospital setting or purchased “over-the-counter” for support of strains and sprains; orthopedic shoes, which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts, except for podiatric appliances when provided in conjunction with treatment of diabetes.
- Any drugs and medicines except as may be provided under the Prescription Drug Program that are: (1) Dispensed by a Pharmacy and received by the Participant while covered under this Contract; (2) dispensed in a Provider’s office or during confinement in a Hospital or other acute care institution of facility and received by the Participant for use on an outpatient basis; (3) over-the-counter drugs and medicines or for which no charge is made, (4) prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations, (5) Retin-A or pharmacological similar topical drugs, or (5) smoking cessation prescription drug products requiring a Prescription Order.
- Any services and supplies for skilled nursing care, Hospice Care and Home Health Care.
- Any services or supplies for organ and tissue transplants.
- Any services or supplies not specifically defined as Eligible Expenses in the Contract.

***The benefits provided under the Prescription Drug Program are not available for:***

- Drugs which do not by law require a Prescription Order from a Provider (**except** injectable insulin); and drugs, or covered devices for which no valid Prescription Order is obtained.
- Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraception devices is provided under the medical portion of the Contract.
- Administration or injection of any drugs.
- Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
- Drugs dispensed in a Physician’s office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under the Workers’ Compensation law.
- Covered Drugs, devices, or other Pharmacy services or supplies covered in whole or in part by any laws of the United States (including Medicare), a foreign country, state or political subdivision except for Medicaid.
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Drugs for which the Pharmacy’s usual and customary charge to the general public is less than or equal to the Copayment Amount provided under the Contract.

- Infertility medication and fertility medication; prescription contraceptive devices, non-prescription contraceptive materials (except prescription oral contraceptive medications which are Legend Drugs). However, coverage for prescription contraception devices is provided under the medical portion of the Contract.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Drugs required by law to be labeled: “Caution — Limited by Federal Law to Investigational Use,” or experimental drugs, even though a charge is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA).
- Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting; drugs given through routes other than subcutaneously in the home setting. This exception does not apply to dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs, the use or intended use of, which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the Program, or for which benefits have been exhausted.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Any smoking cessation products requiring a Prescription Order.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s).
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form.
- Compounded drugs that do not meet the definition of Compound Drugs as defined in the Contract.

## **V. Renewability**

- A. The coverage of any Subscriber and/or Dependent under the Contract will end on the earliest of the following dates:
- On the last day of the period for which premiums have been paid, subject to the Grace Period.
  - On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
  - At the death of a Participant;
- B. If you are Totally Disabled on the expiration date of this Contract coverage for any continuous illness or injury that began while the Contract is in force shall continue until the earliest of: (1) the date the Participant is no longer Totally Disabled; (2) payment of maximum Contract benefits; or (3) the end of 90 days.

**Total Disability**, for purposes of this Subsection B, means the complete inability of a Participant as a result of injury or sickness to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience, such individual is not in fact engaged in any employment or occupation for wage or profit, and is confined as a bed patient in a Hospital or Facility Other Provider.

- C. This is a single term, non-renewable, short term Contract, and is therefore not intended to be a permanent plan. If you need coverage for an additional period of time, you may apply for a second SelecTEMP Contract. Any condition which may have existed or occurred under the prior Contract will be a Preexisting Condition under the subsequent Contract and will not be covered under the subsequent Contract.

## **VI. Premiums**

- A. The total premium rate for this Contract is \$\_\_\_\_\_. Premiums are payable in advance for the term of the Contract. Your payment options are:
1. Single Payment Plan. Available for 1 to 6 months Benefit Periods. The entire premium must be submitted with the application. Required for a 1 month Benefit Period.
  2. Monthly Bank Draft. Available for 2 to 6-month Benefits Periods. The first month's premium must be submitted with the application along with a completed Bank Draft Authorization Request Form and a blank check marked "void."
- B. The premium rates for this Contract are based on the sex and age of the each adult, the Deductible amount and Benefit Period selected, place of residence, and the number of family members to be included on the Contract. There are no increases in premium during the Benefit Period. Premiums will be calculated based on the age of each adult and Dependent child(ren) to be included under the Contract.
- C. A Grace Period is provided for each premium payment. The Grace Period will be 10 days for monthly or 31 days for quarterly.





**BlueCross BlueShield  
of Texas**