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EL PASO ELECTRIC COMPANY
RETIREE WELFARE BENEFITS PLAN
PRE-65 MEDICAL AND PRESCRIPTION DRUG BENEFITS

SUMMARY PLAN DESCRIPTION

Published as of January 1, 2018

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INTRODUCTION

The El Paso Electric Company Retiree Welfare Benefits Plan (the "**Retiree Welfare Plan**") is a comprehensive welfare benefit plan, also known as a "wrap" benefits plan, that provides medical and prescription drug benefits to eligible retirees of El Paso Electric Company ("**EPE**"). The Retiree Welfare Plan provides different medical and prescription drug benefits to eligible retirees who are age 65 and older and their eligible Dependents (the "**Post-65 Retiree Medical Plan**") and to retirees who have not attained age 65 and their eligible dependents (the "**Pre-65 Retiree Medical Plan**"). This summary plan description ("**SPD**") describes the benefits under the Pre-65 Retiree Medical Plan. The benefits provided under the Post-65 Retiree Medical Plan are described in a separate SPD.

If you are a Retired Employee or Disabled Employee who has not reached age 65, your medical benefits are administered by Blue Cross and Blue Shield of Texas ("**BCBSTX**") and your prescription drug benefits are administered by EnvisionRX.

This SPD only summarizes the benefits under the Pre-65 Retiree Medical Plan. The complete details regarding such benefits are set forth in the formal plan documents. In the event of a conflict between the terms of this SPD and the formal plan documents, the plan documents will control. You may obtain a copy of the plan documents, from the Plan Administrator at the address indicated in the **GENERAL INFORMATION** section of this SPD.

The defined terms in this SPD are capitalized and shown in the appropriate provision in the SPD or in the **DEFINITIONS** section of the SPD. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics maybe section headings describing provisions or they may be defined terms.

The terms "you" and "your" as used in this SPD refer to the Retired Employee or Disabled Employee. Use of the masculine pronoun "his," "he," or "him" will be considered to include the feminine unless the context clearly indicates otherwise.

EXECUTED this 29th day of December 2017

EL PASO ELECTRIC COMPANY

By: _____

Printed Name: William Stiller

Title: Sr VP-Public + Cust Aff + CHRO

OVERVIEW: PRE-65 RETIREE MEDICAL PLAN

Managed Health Care - In-Network Medical Benefits

To receive In-Network Medical Benefits as indicated on your Schedule of Coverage, you must choose Providers within the Network for all care (other than for emergencies). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. You may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

To receive In-Network Medical Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency all care should be preauthorized by calling the toll free Mental Health Helpline indicated on your Identification Card and in this SPD. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claim Administrator to furnish services and supplies for those types of conditions to be considered for In-Network Medical Benefits.

If you choose a Network Provider, the Provider will bill the Claim Administrator - not you - for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by the Claim Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles and Copayment Amounts, subject to the Out-of-Pocket Maximum. You may be required to pay for limited or non-covered services. No claim forms are required.

Managed Health Care - Out-of-Network Medical Benefits

If you choose Out-of-Network Providers, only Out-of-Network Medical Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Medical Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying...

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Deductibles up to the Out-of-Pocket Maximum,
- Limited or non-covered services, and
- Failure to preauthorize penalty.

Out-of-Area Medical Benefits

Out-of-Area Medical Benefits are provided through a traditional indemnity arrangement for Participants residing outside of the Managed Health Care coverage Plan Service Area and, therefore, do not have access to Network Providers.

You may have to submit claims for the services provided and you will be responsible for...

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Deductibles up to the Out-of-Pocket Maximum,
- Limited or non-covered services, and
- Failure to preauthorize penalty.

Prescription Drug Program Benefits

Benefits are provided for those Covered Drugs as explained in the **PRE-65 PRESCRIPTION DRUG PROGRAM** section and shown on your Schedule of Coverage in this SPD. The amount of your copayment under the Pre-65 Retiree Medical Plan depends on whether:

- the Prescription Order is filled at a Participating Pharmacy or through the mail-order program;
- a Generic Drug or Formulary Brand Name Drug is dispensed;
- a Specialty or Non-Formulary Brand Name Drug is dispensed or
- you have reached your Out-of-Pocket Maximum under the Pre-65 Retiree Medical Plan.

El Paso Electric will automatically enroll you in the EnvisionRX Plus Employer Group Retiree PDP under the Post-65 Retiree Medical Plan when you reach age 65 and you may elect to keep this coverage or enroll in the EnvisionRX commercial plan or another Medicare prescription drug plan.

Important Contact Information

BCBSTX Customer Service Helpline	1-800-521-2227	Monday – Friday 8:00 a.m. – 8:00 p.m. Central
BCBSTX Website	www.bcbstx.com	24 hours a day 7 days a week
BCBSTX Medical Preauthorization Helpline	1-800-441-9188	Monday – Friday 7:30 a.m. – 6:00 p.m. Central
BCBSTX Mental Health/Chemical Dependency Preauthorization Helpline	1-800-528-7264	24 hours a day 7 days a week
EnvisionRX Customer Service	1- 800-595-8531	24 hours a day 365 days a year
EnvisionRX Website	www.envisionrx.com	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and ParPlan Providers
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Pre-65 Retiree Medical Plan
- Record comments about Providers
- Assist you with questions regarding the **PRESCRIPTION DRUG PROGRAM**

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this SPD, and much more.

Mental Health/Chemical Dependency Preauthorization Helpline

To satisfy Preauthorization requirements for Participants seeking treatment for Behavioral Health Services, Mental Health Care, Serious Mental Illness, and Chemical Dependency, you, your Behavioral Health Practitioner, or a family member may call the Mental Health/Chemical Dependency Preauthorization Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical Preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

EnvisionRX Website

Visit the EnvisionRX website at www.envisionrx.com for information about EnvisionRX, access to forms referenced in this SPD, and much more

WHO GETS BENEFITS UNDER THE MEDICAL AND PRESCRIPTION DRUG PROGRAM

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Retiree Welfare Plan.

Retired Employee Eligibility

You are eligible for medical and prescription drug coverage under the Retiree Welfare Plan if you are a Retired Employee. Depending on your age, medical and prescription drug coverage under the Retiree Welfare Plan may be under the Post-65 Retiree Medical Plan or the Pre-65 Retiree Medical Plan.

If you would qualify as a Retired Employee except that you do not elect to commence benefits or receive a lump sum distribution of your benefits under the Retirement Plan at the time of such termination of employment, you will not be eligible for medical and prescription drug benefits

under the Retiree Welfare Plan. Similarly, if you are a Retired Employee but you do not elect coverage under the Retiree Welfare Plan when you are first eligible, you may not elect medical and prescription drug coverage under the Retiree Welfare Plan during any future open enrollment period. In both of these instances where you cannot obtain medical and prescription drug coverage under the Retiree Welfare Plan, you may, however, be entitled to elect COBRA continuation coverage under the medical and prescription drug program under the Employee Welfare Benefits Plan (the "**Employee Medical Plan**"); provided that you are enrolled in the Employee Medical Plan at the time of your retirement.

If you are a Retired Employee who is enrolled in the medical and prescription drug coverage under the Retiree Welfare Plan and you cancel coverage for yourself or your Eligible Dependents, you will not be able to enroll yourself or such dependents in medical and prescription drug coverage under the Retiree Welfare Plan at a later time. Generally, your coverage will end on the last day of the last month for which your premium was paid in full.

If you are a Retired Employee who is covered by the medical and prescription drug coverage under the Retiree Welfare Plan and are rehired in any capacity (i.e., as a permanent employee, temporary employee, contract employee, independent contractor or leased employee) (a "**Rehired Employee**") you will be eligible for medical and prescription drug coverage offered under the Employee Medical Plan at the time of your reemployment which will be communicated to you at the time of your reemployment and you will not be required to satisfy any waiting period. You will pay the active employee rate for the coverage you elect to enroll in under the Employee Medical Plan. You may enroll yourself and your Dependents who were covered under the medical and prescription drug coverage under the Retiree Welfare Plan at the time of your reemployment. However, unlike the medical and prescription drug coverage under the Retiree Welfare Plan, you will have special enrollment rights under the Employee Medical Plan, meaning you may add newly acquired Dependents under the Employee Medical Plan. Upon your subsequent cessation of employment you will be able to enroll in the medical and prescription drug coverage offered under the Retiree Welfare Plan at that time and enroll any Dependents who were covered under the Retiree Welfare Plan at the time of your reemployment as a Rehired Employee. Any Dependents you enrolled in the Employee Medical Plan during your period of reemployment will be eligible to elect to continue coverage under the Employee Medical Plan pursuant to COBRA. Any applicable Pre-Existing Condition limitation under the Retiree Welfare Plan will be reduced or eliminated by your and your Dependent's previous period of coverage under the medical and prescription drug coverage under the Retiree Welfare Plan and the Employee Medical Plan.

Disabled Employee Eligibility

You are eligible for medical and prescription drug coverage under the Retiree Welfare Plan if you are a Disabled Employee. Depending on your age, medical and prescription drug coverage under the Retiree Welfare Plan may be under the Post-65 Retiree Medical Plan or the Pre-65 Retiree Medical Plan. If you qualify for disability under the Social Security Act you will be eligible for the Post-65 Retirement Medical Plan.

If you are a Disabled Employee but you do not elect medical and prescription drug coverage under the Retiree Welfare Plan when you are first eligible, you may not elect medical and prescription drug coverage under the Retiree Welfare Plan during any future open enrollment period. In the event you do not obtain medical and prescription drug coverage under the Retiree Welfare Plan, you may be entitled to elect COBRA continuation coverage under the

Employee Medical Plan, provided that you are enrolled in the Employee Medical Plan at the time of your disability retirement.

The Plan Administrator may periodically require proof of your continued disability as a condition to your ongoing medical and prescription drug coverage under the Retiree Welfare Plan.

If you are a Disabled Employee who is enrolled in medical and prescription drug coverage under the Retiree Welfare Plan and you cancel coverage for yourself or your Eligible Dependents, you will not be able to enroll yourself or such dependents in medical and prescription drug coverage under the Retiree Welfare Plan at a later time.

If you are a Disabled Employee who is covered by the medical and prescription drug coverage under the Retiree Welfare Plan and you recover from such disability and you become a Rehired Employee (i.e., rehired as a permanent employee, temporary employee, contract employee, independent contractor or leased employee), you will be eligible for medical and prescription drug coverage under the Employee Medical Plan the date of your reemployment and you will not be required to satisfy any waiting period. You may enroll yourself and your Dependents who were covered under the medical and prescription drug coverage under the Retiree Welfare Plan at the time of your reemployment. However, unlike the medical and prescription drug coverage under the Retiree Welfare Plan, you will have special enrollment rights under the Employee Medical Plan, meaning you may add newly acquired Dependents under the Employee Medical Plan. Upon your subsequent cessation of employment you will be able to recommence your medical and prescription drug coverage under the Retiree Welfare Plan for yourself and your Dependents who were enrolled in the Employee Medical Plan at the time of your termination as a Rehired Employee. Any applicable Pre-Existing Condition limitation under the medical and prescription drug coverage under the Retiree Welfare Plan will be reduced or eliminated by any previous period of medical and prescription drug coverage under the Retiree Welfare Plan or the Employee Medical Plan.

Dependent Eligibility

If you apply for medical and prescription drug coverage under the Retiree Welfare Plan, you may include your Dependents; provided they were enrolled as your dependents under the Employee Medical Plan at the time of your regular or disability retirement. Eligible Dependents are:

1. Your Spouse for his or her lifetime;
2. Your Dependent Child under age 26

A detailed description of Dependent is in the **DEFINITIONS** section of this SPD. A Retired Employee or Disabled Employee must be covered first in order to cover his eligible Dependents. No Dependent will be covered under the medical and prescription drug coverage under the Retiree Welfare Plan before the Retired Employee's or Disabled Employee's, as applicable, Effective Date. Depending on the age of your Dependent, medical and prescription drug coverage under the Retiree Welfare Plan may be under the Post-65 Retiree Medical Plan or the Pre-65 Retiree Medical Plan.

Surviving Spouse / Dependent Children

Your Surviving Spouse who is enrolled in the medical and prescription drug coverage under the Retiree Welfare Plan is eligible to continue medical and prescription drug coverage upon your death for as long as your Surviving Spouse remains unmarried. In the event your Surviving

Spouse marries, coverage will end on the date of the marriage. Dependent Children who were covered under the Plan at the time of your passing will have the option of continuing medical and prescription drug coverage under the Plan under the Surviving Spouse's coverage so long as they continue to meet the definition of a Dependent. Depending on the age of your Surviving Spouse, medical and prescription drug coverage under the Retiree Welfare Plan may be under the Post-65 Retiree Medical Plan or the Pre-65 Retiree Medical Plan.

In addition, the Surviving Spouse of an Employee who is enrolled in the Employee Medical Plan is eligible to continue medical and prescription drug coverage upon the Employee's death under the Retiree Welfare Plan for as long as he or she remains unmarried. In the event the Employee's Surviving Spouse marries, coverage will end on the date of the marriage. Dependent Children who were covered under the Employee Medical Plan at the time of the Employee's passing will have the option of continuing medical and prescription drug coverage under the Retiree Plan under the Surviving Spouse's coverage so long as they continue to meet the definition of a Dependent.

Coverage as a Retired Employee or Disabled Employee and Dependent

In no event may a person be simultaneously covered under the Plan as both a Retired Employee or Disabled Employee and a Dependent. In no event will any Dependent be covered as a Dependent of more than one Retired Employee or Disabled Employee (and/or active Employee) who is covered under the Plan (or Employee Medical Plan). If a husband and wife are both eligible for Retired Employee or Disabled Employee coverage, either, but not both, can apply for coverage for any eligible Dependent.

Premiums

EPE pays for a portion of your medical and prescription drug coverage under the Retiree Welfare Plan so that you are not required to pay for the entire cost of coverage. Effective as of January 1, 2014, EPE is limiting the amount it will pay for your coverage, to an aggregate average of $10,000 per retiree, as periodically adjusted for inflation beginning January 1, 2013. This means that when EPE's aggregate average cost per retiree exceeds the $10,000 adjusted limit, EPE's cost sharing will remain at $10,000 (as adjusted) and you will be required to pay a larger portion of your retiree medical and prescription drug coverage. Your increased cost may take the form of higher retiree premiums or design changes such as higher deductibles or co-pays.

Dependent Verification Process

The purpose of the Dependent Verification Process is to ensure EPE provides high-quality, cost effective healthcare coverage to eligible Retired Employees or Disabled Employees and their eligible Dependents. EPE may request verification from your Surviving Spouse that he or she is unmarried.

Documentation Required When Enrolling a Dependent

Dependents whose medical and prescription drug coverage continued under the Retiree Welfare Plan at the time of the Retired Employee's or Disabled Employee's initial enrollment must complete an eligibility verification process. If a Retired Employee or Disabled Employee continues a Dependent's coverage, he will receive a notice from the EPE Human Resources department and will be required to submit appropriate documentation within 31 days. If verification is not completed by the deadline, EPE will retroactively remove the Dependent as of

the coverage effective date and such Dependent will not be subsequently eligible to enroll in the medical and prescription drug coverage under the Retiree Welfare Plan.

Remember only Dependents who were covered under the Employee Medical Plan at the time of the Retired Employee's retirement or Disabled Employee's disability retirement are eligible to continue medical and prescription drug coverage under the Retiree Welfare Plan.

Dependent Eligibility Audits

EPE conducts dependent eligibility audits to ensure only eligible Dependents are covered under the medical and prescription drug coverage under the Retiree Welfare Plan. Severe penalties, including the loss of coverage and liability for repayment, could apply if you knowingly attempt to cover or continue to cover anyone who is not eligible.

During the dependent audit process, EPE will select Retired Employees and Disabled Employees covering any type of Dependent and require them to submit documentation of eligibility (includes Spouse, common law spouse Dependent Child).

Retired Employees and Disabled Employees must submit the required documentation by the deadline indicated by EPE (see section ***Documentation Required When Enrolling a Dependent***). If a Retired Employee or Disabled Employee does not respond by the date indicated, the Dependent will be removed from medical and prescription drug coverage under the Retiree Welfare Plan as of the end of the month in which the request was made and such Dependent will not be subsequently eligible to enroll in the medical and prescription drug coverage under the Retiree Welfare Plan.

Effective Dates of Coverage

In order for your coverage to take effect, you must enroll for medical and prescription drug coverage under the Retiree Welfare Plan for yourself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Retiree Welfare Plan is shown on your identification card. It may be different from the Eligibility Date. Also, Depending on the age of your Dependent, medical and prescription drug coverage under the Retiree Welfare Plan may be under the Post-65 Retiree Medical Plan or the Pre-65 Retiree Medical Plan.

Timely Applications

It is important that your application for medical and prescription drug coverage under the Retiree Welfare Plan is received timely by the Plan Administrator.

If you apply for medical and prescription drug coverage under the Retiree Welfare Plan when you first become a Retired Employee or Disabled Employee and your application is received by the Plan Administrator prior to or within 31 days of your Eligibility Date and you make the required contributions for yourself or for yourself and your eligible Dependents coverage will become effective on the date of your retirement.

Each year during the Open Enrollment Period you will be entitled to elect to change your medical and prescription drug coverage under the Retiree Welfare Plan or withdraw from the Retiree Welfare Plan. However, you will not be able to enroll any new Dependents. If you choose to drop you or your Dependents' medical and prescription drug coverage under the Retiree Welfare Plan during the Open Enrollment Period, you will not be allowed to reenroll

during any subsequent Open Enrollment Period. Unless the open enrollment materials provide otherwise, if you do not complete and return a new enrollment form during the Open Enrollment Period, you will be treated as having elected to continue the benefit coverage then in effect for the following year.

In addition, you may elect to change your Spouse's medical and prescription drug coverage under the Plan (e.g., switch from the Pre-65 Retiree Medical Plan to the Post-65 Retiree Medical Plan) when your Spouse becomes entitled to Medicare Benefits. In connection with such a change in your Spouse's medical and prescription drug coverage, or when your Dependent Child reaches age 26, you may also change the level of coverage under the Pre-65 Retiree Medical Plan (i.e., switch from the PPO to the HDHP). You must apply for any such change in coverage within 31 days of the date of the event giving rise to the change (i.e., Medicare entitlement or Dependent Child's attainment of 26) and make the required premiums for yourself or for yourself and your eligible Dependents. Your change in coverage will become effective as soon as practicable after you have submitted a complete application and provided all other documentation required by the Plan Administrator.

Group Enrollment Application/Change Form

Use this form to...

- Notify the Retiree Welfare Plan of a change to your name
- Add eligible Dependents upon your initial enrollment in the medical and prescription drug coverage under the Retiree Welfare Plan
- Drop Dependents
- Cancel all or a portion of your coverage
- Notify the Retiree Welfare Plan of all changes in address for yourself and your Dependents. An address change may result in benefit changes for you and your Dependents if you move out of the plan service area.

You may obtain this form from the Plan Administrator. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to the Plan Administrator.

Changes In Your Family

You (or your Surviving Spouse) should promptly notify the Plan Administrator when you divorce, or your Surviving Spouse remarries, or your Child reaches the age 26 or a Participant in your family dies; medical and prescription drug coverage under the Retiree Welfare Plan terminates in accordance with the **Termination of Coverage** provisions contained in this SPD.

Notify the Plan Administrator promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If you or your Dependent's medical and prescription drug coverage under the Retiree Welfare Plan is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Plan Administrator, refunds will be requested.

Please refer to the **Continuation of Group Coverage - Federal** subsection in this SPD for additional information.

Termination of Coverage

Neither the Plan Administrator or Claim Administrator is required to give you prior notice of termination of medical and prescription drug coverage under the Retiree Welfare Plan. The Plan Administrator and Claim Administrator will not always know of the events causing termination until after the events have occurred. In addition, you or your Dependents may elect to drop medical and prescription drug coverage under the Retiree Welfare Plan at any time by giving notice to the Plan Administrator. The effective date of the termination of coverage will be the last day of the month in which you provide notice (e.g., if you provide notice on the 15th of month one, your coverage will end the last day of month one). **Once you or your Dependents elect to drop medical and prescription drug coverage under the Retiree Welfare Plan you will not be permitted to re-enroll.**

Termination of Individual Coverage

Medical and prescription drug coverage under the Retiree Welfare Plan for you and/or your Dependents will automatically terminate on the last day of the month when any of the following occur:

1. Your contribution for coverage under the Retiree Welfare Plan is not received timely by the Plan Administrator, in which case, coverage will end as of the last day of the last month for which your premium was timely received; or
2. You no longer satisfy the definition of a Retired Employee or Disabled Employee as defined in this SPD; provided, however, that in the event of your death, coverage will end on the day after your death; or
3. You request to drop coverage; or
4. In the case of a Surviving Spouse, the date the Surviving Spouse remarries or the last day of the month following the date on which the Surviving Spouse requests to drop coverage; or
5. The medical and prescription drug coverage under the Retiree Welfare Plan is terminated or amended to terminate the coverage of the class of Retired Employees or Disabled Employees to which you belong; or
6. A Dependent ceases to be a Dependent as defined in this SPD; provided, however, that in the event of the Dependent's death, coverage will end on the day after the Dependent's death, or, in the case of a Dependent covered under a Surviving Spouse's coverage, on the day the Surviving Spouse remarries or the last day of the month in which the Dependent (or the Retired Employee, Disabled Employee, or Spouse in the case of a minor dependent) requests to drop medical and prescription drug coverage under the Retiree Welfare Plan; or
7. The Retiree Welfare Plan no longer provides Dependent medical and prescription drug coverage.

However, when the sixth event occurs, your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage - Federal in the GENERAL PROVISIONS** section of this SPD.

The Plan Administrator may refuse to renew the medical and prescription drug coverage of an eligible Retired Employee or Disabled Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Medical and prescription drug coverage for a Child of any age who is medically certified as Disabled and dependent on the parent will not terminate upon 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.

Coverage for such a Disabled Child will end on the **earliest** of: (i) the cessation of the Disability, (ii) the date you fail to provide periodic certification of the Child's physical or medical condition as described in the following paragraph, or (iii) upon the Child's no longer being dependent upon you for his support.

Disabled means any medically determinable physical or mental condition that prevents the Child from engaging in self-sustaining employment. The disability must begin while the Child is covered under the medical and prescription drug coverage under the Retiree Welfare Plan (or the Employee Medical Plan) and before the Child attains age 26. You must submit satisfactory proof of the disability and dependency to your Plan Administrator within 31 days following the Child's attainment of the age 26. As a condition to the continued coverage of a Child as a Disabled Dependent beyond age 26, the Plan Administrator may require periodic certification of the Child's physical or mental condition but not more frequently than annually after the two-year period following the Child's attainment of age 26.

MEDICAL BENEFITS

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Pre-65 Retiree Medical Plan will pay for Eligible Expenses you incur under the Pre-65 Retiree Medical Plan. The Pre-65 Retiree Medical Plan has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with BCBSTX or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services, supplies, or care from a Provider that does not contract with BCBSTX, you will be responsible for any difference between the Allowable Amount and the amount charged by the non-contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Pre-65 Retiree Medical Plan, any applicable Deductibles, Out-of-Pocket Maximum, and Copayment Amounts.

Review the definition of Allowable Amount in the **DEFINITIONS** section of this SPD to understand the guidelines used by BCBSTX in processing claims under the Pre-65 Retiree Medical Plan.

Freedom of Choice

Each time you need medical care, you can choose to:		
• You receive the higher level of benefits (In-Network Medical Benefits) • You are not required to file	• You receive the lower level of benefits (Out-of-Network Medical Benefits) • You are not required to file	• You receive the lower level of benefits (Out-of-Network Medical Benefits) • You are required to file your

claim forms	claim forms in most cases; ParPlan Providers will usually file claims for you	own claim forms
• You are not balance billed; Network Providers will not bill for costs exceeding the Claim Administrator's Allowable Amount for covered services	• You are not balance billed; ParPlan Providers will not bill for costs exceeding the Claim Administrator's Allowable Amount for covered services	• You may be billed for charges exceeding the Claim Administrator's Allowable Amount for covered services
• Your Provider will preauthorize necessary services	• In most cases, ParPlan Providers will preauthorize necessary services	• You must preauthorize necessary services

Case Management

Under certain circumstances, the Pre-65 Retiree Medical Plan provides benefits for expenses which are not otherwise Eligible Expenses. BCBSTX or the Plan Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- It is anticipated that future expenditures for Eligible Expenses may be reduced by such benefits or other circumstances warrant such coverage.

Any decision by BCBSTX or the Plan Administrator to provide such benefits will be made on a case-by-case basis. The case coordinator for BCBSTX will initiate case management in appropriate situations.

Identification Card

The Identification Card tells Providers that you are entitled to benefits under the Pre-65 Retiree Medical Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number.*** This unique identification number is preceded by a three character alpha prefix that identifies BCBSTX and EnvisionRX, as applicable, as your Claim Administrators.
- ***Your group number.*** This is the number assigned to identify the Pre-65 Retiree Medical Plan with BCBSTX and EnvisionRX.
- ***Any Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers.***

Always remember to carry your Identification Card with you and present it to your Providers when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, you will be provided a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:
   a) Use of the Identification Card prior to your Effective Date;
   b) Use of the Identification Card after your date of termination of coverage under the Pre-65 Retiree Medical Plan;
   c) Obtaining other benefits for persons not covered under the Pre-65 Retiree Medical Plan;
   d) Obtaining other benefits that are not covered under the Pre-65 Retiree Medical Plan.
2. The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:
   a) Denial of benefits;
   b) Cancellation of coverage under the Pre-65 Retiree Medical Plan for all Participants under your coverage;
   c) Limitation on the use of the Identification Card to one designated Physician, Other Provider of your choice;
   d) Recoupment from you or any of your covered Dependents of any benefit payments made;
   e) Pre-approval of medical services for all Participants receiving benefits under your coverage;
   f) Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which medical benefits are available under the Pre-65 Retiree Medical Plan must be Medically Necessary as determined by BCBSTX. Charges for services and supplies which BCBSTX determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Out-of-Pocket Maximum.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in the ParPlan which is a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the ParPlan, he agrees to:

- File all claims for you,
- Accept BCBSTX's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out-of-Network Medical Benefits as outlined in this SPD; however, you will still be responsible for:

- Any Deductibles,
- Out-of-Pocket Maximum, and
- Services that are limited or not covered under the Pre-65 Retiree Medical Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the ParPlan, please contact the BCBSTX Customer Service Helpline.

Pre-existing Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a Pre-existing Condition will not be available during the 12-month period following the Participant's initial Effective Date of Coverage.

The Pre-existing Condition exclusion **will not apply** to:

1. Any individual under age 19; or

2. A newborn child who was enrolled in the Employee Medical Plan at the time of the Retired Employee's retirement or Disabled Employee's disability retirement and whose coverage is continued under the Pre-65 Retiree Medical Plan in connection with the Retired Employee's or Disabled Employee's initial enrollment in the Pre-65 Retiree Medical Plan; or

3. A child who is adopted or involved in a suit for adoption before attaining age 26 and who was enrolled in the Employee Medical Plan at the time of the Retired Employee's retirement or Disabled Employee's disability retirement and whose coverage is continued under the Pre-65 Retiree Medical Plan in connection with the Retired Employee's or Disabled Employee's initial enrollment in the Pre-65 Retiree Medical Plan; or

4. An individual who was continuously covered for an aggregate period of 12 months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of coverage under the Pre-65 Retiree Medical Plan.

The Plan Administrator will credit the time you were covered under Creditable Coverage if the previous coverage was in effect at any time during the twelve months prior to the Effective Date of coverage under this Pre-65 Retiree Medical Plan, including credit for any waiting period that applied before that Creditable Coverage became effective.

Pregnancy, conditions resulting from domestic violence and genetic information without a diagnosis of a specific condition will not be considered a Pre-existing Condition.

All other terms, provisions, limitations, and exclusions will apply to all Participants even if any Pre-existing Condition exclusion is not applicable for the reasons set out above.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Medical Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In-Network Medical Benefits will be provided when you use Out-of-Network Providers.

- If you elect to see an Out-of-Network Provider and if the services could have been provided by a Network Provider, only Out-of-Network Medical Benefits will be available.

Use of Non-Contracting Providers

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 Medical Benefits (the lower level of benefits). Benefits for covered services will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this SPD. **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 Pre-65 Retiree Medical Plan and any applicable Deductibles, Out-of-Pocket Maximum, and Copayment Amounts.

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under the Pre-65 Retiree Medical 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 Pre-65 Retiree Medical Plan, such as Pre-existing Conditions, 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 and outpatient treatment of Chemical Dependency,
- All inpatient and outpatient treatment of Mental Health Care,
- All inpatient and outpatient treatment of Serious Mental Illness, and
- If you transfer to another facility or to or from a specialty unit within the facility.

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

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

However, if care is not available from Network Providers as determined by BCBSTX, and BCBSTX acknowledges your visit to an Out-of-Network Provider **prior to the visit**, In-Network

Medical 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.

Out-of-Area Benefits will be available subject to all Pre-65 Retiree Medical Plan provisions, if you receive care in a Network Facility and the services have been preauthorized.

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 below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the section entitled Failure to Preauthorize.

Preauthorization for Inpatient Hospital Admissions

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 an emergency, Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

To satisfy Preauthorization requirements, on business days between 7:30 a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Medical 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 Medical 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 Medical Benefits will be paid.

When an inpatient Hospital Admission is Preauthorized, a length-of-stay is assigned. If you require a longer stay than was first Preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested. Your Pre-65 Retiree Medical Plan is required to provide a minimum length-of-stay in a Hospital facility for the following:

- 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

You or your Provider will not be required to obtain Preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Preauthorization from BCBSTX.

Preauthorization for Extended Care Expenses and Home Infusion Therapy. Preauthorization for Extended Care Expenses and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact the Claim Administrator to request Preauthorization. The request should be made:

- Prior to initiating Extended Care Expenses or Home Infusion Therapy;
- When an extension of the initially Preauthorized service is required; and
- When the treatment plan is altered.

BCBSTX will review the information submitted prior to the start of Extended Care Expenses or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If Extended Care Expenses or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the BCBSTX Medical Preauthorization Helpline telephone number indicated in this SPD or shown on your Identification Card.

If BCBSTX has given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

***Preauthorization for Mental Health Care,* Serious Mental Illness, and Treatment of Chemical Dependency.** In order to receive maximum benefits, all inpatient treatment and outpatient treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency must be Preauthorized.

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 indicated in this SPD or 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.

In-Network Medical 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 Medical 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 Medical Benefits will be paid; otherwise, Out-of-Network Medical Benefits will be paid.

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.

Failure to Preauthorize

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and 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, if indicated on your Schedule of Coverage:
  -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 Experimental/Investigational, benefits will be reduced or denied.

Eligible Expenses

The Pre-65 Retiree Medical Plan provides medical coverage for four categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to your Schedule(s) in this SPD. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Copayment Amounts

Some of the medical care and treatment you receive under the Pre-65 Retiree Medical Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under "Copayment Amounts Required" for your specific Pre-65 Retiree Medical Plan information.

A Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a family practitioner, a

general practitioner, an obstetrician/gynecologist, a pediatrician, an internist or a Professional Other Provider and defined in the **DEFINITIONS** section of this SPD. A Copayment Amount is required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

A different Copayment Amount as indicated on your Schedule of Coverage will be required for each Physician office visit charge you incur when services are received by a Specialty Care Provider as classified by the American Board of Medical Specialties as a Specialty Care Provider.

In-Network ***Preventive Care Services*** are not subject to this Copayment Amount provision.

The following services are not payable under this Copayment Amount provision but instead are considered Medical-Surgical Expense and may be subject to any Deductible shown on your Schedule of Coverage:

- surgery performed in the Physician's office;
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an office visit;
- therapeutic injections;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount will be required for each visit to an Urgent Care Center. If the services provided require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. The following services are not payable under this Copayment Amount provision but instead are considered Medical—Surgical Expense, shown on your Schedule of Coverage:

- surgery performed in the Urgent Care center;
- physical therapy billed separately from an Urgent Care visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an Urgent Care visit;
- therapeutic injections;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived.

Deductibles

The medical benefits under the Pre-65 Retiree Medical Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

Per-admission Deductible: The per-admission Deductible shown under "Deductibles" on your Schedule of Coverage will apply to each inpatient Hospital Admission of a Participant.

Calendar Year Deductible: The individual Deductible amount shown under "Deductibles" on your Schedule of Coverage must be satisfied by each Participant under your medical coverage each Calendar Year. This Deductible, unless otherwise indicated, will be applied to all categories of Eligible Expenses before benefits are available under the Pre-65 Retiree Medical Plan.

The following are exceptions to the Deductibles described above:

In-Network ***Preventive Care Services*** are not subject to Deductibles.

If you have several covered Dependents, all charges used to apply toward an "individual" Deductible amount will be applied toward the "family" Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "family" Deductible amount.

Out-of-Pocket Maximum

Most of your Eligible Expense payment obligations including Copayment Amounts are applied to the Out-of-Pocket Maximum. Separate Out-of-Pocket Maximums apply to your medical benefits and to your prescription drug benefits under the Pre-65 Retiree Medical Plan.

Your Out-of-Pocket Maximum will not include:

- Services, supplies, or charges limited or excluded by the Pre-65 Retiree Medical Plan;
- Expenses not covered because a visit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when the Pre-65 Retiree Medical Plan is the Secondary Plan for purposes of coordination of benefits;
- Penalties applied for failure to preauthorize;

Individual Out-of-Pocket Maximum

When the Out-of-Pocket Maximum Amount for the In-Network, Out-of-Network, or Out-of-Area Medical Benefits level for a Participant in a Calendar Year equals the "individual" "Out-of-Pocket Maximum" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the medical benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Out-of-Pocket Maximum

When the Out-of-Pocket Maximum Amount for the In-Network, Out-of-Network, or Out-of-Area Medical Benefits level for all Participants under your coverage in a Calendar Year equals the

"family" "Out-of-Pocket Maximum" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the medical benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family "Out-of-Pocket Maximum."

The following are exceptions to the Out-of-Pocket Maximums described above:

There are separate Out-of-Pocket Maximums for In-Network Medical Benefits and Out-of-Network Medical Benefits.

Eligible Expenses applied toward satisfying the "individual" Out-of-Pocket Maximum will apply toward both the In-Network and the Out-of-Network "Out-of-Pocket Maximum" maximum shown on your Schedule of Coverage. Eligible Expenses applied toward satisfying the "family" Out-of-Pocket Maximum will apply toward both the In-Network and the Out-of-Network "Out-of-Pocket Maximum" shown on your Schedule of Coverage.

Copayment Amounts for In-Network Medical Benefits and Out-of-Network Medical Benefits will continue to be required after the benefit percentages become 100%.

Maximum Lifetime Benefit

The Maximum Lifetime Benefit of the Pre-65 Retiree Medical Plan as shown in the Schedule of Coverage applies separately to you, your Spouse, and each of your Dependents. The total payments under the Pre-65 Retiree Medical Plan will not exceed that maximum whether or not you, your Spouse, or Dependents are continuously covered under the Pre-65 Retiree Medical Plan. Claims incurred under the Employee Medical Plan do not count toward the Maximum Lifetime Benefit under the Pre-65 Retiree Medical Plan.

Changes In Benefits

Changes to covered medical benefits will apply to all services provided to each Participant under the Pre-65 Retiree Medical Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

Inpatient Hospital Expenses

The Pre-65 Retiree Medical Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this SPD for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under "Inpatient Hospital Expenses" on your Schedule of Coverage, and subject to the Out-of-Pocket Maximum is the Pre-65 Retiree Medical Plan's obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible until the Out-of-Pocket Maximum is met, is your obligation to pay. This excess amount will be applied to the Out-of-Pocket Maximum.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Medical Benefits when those services and supplies are not available from a Network Provider provided BCBSTX acknowledges your visit to an Out-of-Network Provider prior to the visit. Otherwise,

Out-of-Network Medical 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 on your Schedule of Coverage is the Pre-65 Retiree Medical Plan's obligation. The remaining unpaid Inpatient Hospital Expense in excess of any Deductible until the Out-of-Pocket Maximum is met is your obligation to pay. This excess amount will be applied to the Out-of-Pocket Maximum.

Refer to your Schedule of Coverage for information regarding Deductibles, Out-of-Pocket Maximum percentages, and penalties for failure to preauthorize that may apply to your coverage.

Covered Medical-Surgical Expenses

The Pre-65 Retiree Medical Plan provides coverage for Medical-Surgical Expense for you and your covered Dependents. Some services require Preauthorization. Refer to the PREAUTHORIZATION REQUIREMENTS subsection of this SPD for more information.

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" on your Schedule of Coverage in excess of your Copayment Amounts, Out-of-Pocket Maximum, and any applicable Deductibles shown are the Pre-65 Retiree Medical Plan's obligation.

Medical-Surgical Expense will include:

1. Services of Physicians and Professional Other Providers.

2. Consultation services of a Physician and Professional Other Provider.

3. Services of a certified registered nurse-anesthetist ("**CRNA**").

4. Diagnostic x-ray and laboratory procedures.

5. Radiation therapy.

6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Pre-65 Retiree Medical Plan. The term "durable medical equipment ("**DME**") will not include:

    a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or
    b. 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.

7. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.

8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.

9. Oxygen and its administration provided the oxygen is actually used.

10. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.

11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.

12. 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 part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

13. Home Infusion Therapy.

14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.

15. Certain Diagnostic Procedures.

16. Outpatient Contraceptive Services.

17. Foot care, including foot orthodics, in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.

18. Injectable drugs, administered by or under the direction or supervision of a Physician or Professional Other Provider.

19. Elective Abortions.

20. Elective Sterilizations.

Covered Extended Care Expenses

The Pre-65 Retiree Medical Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require Preauthorization. Refer to the PREAUTHORIZATION REQUIREMENTS subsection of this SPD for more information.

The Pre-65 Retiree Medical Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and
2. Up to the amount of the combined benefit maximums shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Pre-65 Medical Plan, whether under the In-Network or Out-of-Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

Out-of-Area benefits are not available unless services are rendered by a Network Facility and have been preauthorized and approved by BCBSTX.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Out-of-Pocket Maximum.

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:

1. For Skilled Nursing Facility:
   a) 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.);
   b) Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
   c) Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:
   a) 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.);
   b) Part-time or intermittent home health aide services which consist primarily of caring for the patient;
   c) Physical, occupational, speech, and respiratory therapy services by licensed therapists;
   d) Supplies and equipment routinely provided by the Home Health Agency.

Benefits will not be provided for Home Health Care for the following:

- Food or home delivered meals;
- Social case work or homemaker services;
- Services provided primarily for Custodial Care;
- Transportation services;
- Home Infusion Therapy;
- Durable medical equipment.

3. For Home Hospice Care:

   a) 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.);
   b) Part-time or intermittent home health aide services which consist primarily of caring for the patient;
   c) Physical, speech, and respiratory therapy services by licensed therapists;
   d) Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

4. Facility Hospice Care.

a) 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.);
b) Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
c) Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical-Surgical Expenses, and Extended Care Expenses, except to the extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Preauthorization and that any Copayment Amounts, Out-of-Pocket Maximum, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this SPD for more information.

Benefits for Treatment of 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.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent Children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a Child will be considered Maternity Care and are subject to all provisions of the Pre-65 Retiree Medical Plan.

The Pre-65 Retiree Medical 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 Pre-65 Retiree Medical Plan provides coverage for Post-delivery Care for the mother and newborn. The Post-delivery Care may be provided at the mother's home, a health care Provider's office, or a health care facility.

Post-delivery 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 on your Schedule of Coverage.

Benefits for Emergency Care and Treatment of Accidental Injury

The Pre-65 Retiree Medical 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 on your Schedule of Coverage. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room/treatment room visit as indicated on your 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 Medical 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 Medical Benefits will be available

Notwithstanding anything in this SPD to the contrary, for Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount will be equal to the greatest of the following three possible amounts-not to exceed billed charges:

1. the median amount negotiated with In-Network Providers for Emergency Care services furnished;
2. the amount for the Emergency Care service calculated using the same method the Pre-65 Retiree Medical 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
3. the amount that would be paid under Medicare for the Emergency Care service.

Each of these three amounts is calculated excluding any In-Network Copayment or Out-of-Pocket Maximum imposed with respect to the Participant.

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. A Copayment Amount, in the amount indicated on your Schedule of Coverage, will be required for each Urgent Care visit. Urgent Care 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.

Benefits for Speech and Hearing Services

Benefits as shown on your 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.

Any benefit payments made by the Claim Administrator for hearing aids, whether under the In-Network, Out-of-Network, or Out-of-Area Benefits level, will apply toward the benefit maximum amount indicated on your Schedule of Coverage for each level of benefits.

Benefits for 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 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.

Benefits for 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 on your Schedule of Coverage only for the following:

- 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, un-restored natural teeth and supporting tissues and limited to treatment provided within

24 months of the initial treatment. An injury sustained as a result of biting or chewing will not be considered an Accidental Injury.

- Diagnostic and surgical treatment of conditions affecting the temporomandibular joint and craniomandibular joint (excluding dental treatment and appliances),

Any other dental services, except as excluded in the MEDICAL LIMITATIONS AND EXCLUSIONS section of this SPD, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in Benefits for Inpatient Hospital Expenses.

Benefits for Organ and Tissue Transplants

a. 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:

   1) The transplant procedure is not Experimental/Investigational in nature; and
   2) Donated human organs or tissue or an FDA-approved artificial device are used; and
   3) The recipient is a Participant under the Pre-65 Retiree Medical Plan; and
   4) The transplant procedure is preauthorized as required under the Pre-65 Retiree Medical Plan; and
   5) The Participant meets all of the criteria established by BCBSTX in pertinent written medical policies; and
   6) 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, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

b. Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is considered Medically Necessary and meets all of the conditions cited above.

   Benefits will be available for:

   1) A recipient who is covered under the Pre-65 Retiree Medical Plan; and
   2) A donor who is a Participant under the Pre-65 Retiree Medical Plan.

c. Covered services and supplies include services and supplies provided for the:

   1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
   2) Removal of organs or tissues from living or deceased donors; and
   3) Transportation and short-term storage of donated organs or tissues.

d. No benefits are available for a Participant for the following services or supplies:

   1) Donor search and acceptability testing of potential live donors;
   2) Living and/or travel expenses of the recipient or a live donor;

3) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
4) Purchase of the organ or tissue; or
5) Organs or tissue (xenograft) obtained from another species.

e. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this SPD for more specific information about Preauthorization.

1) Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
2) At the time of Preauthorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

f. 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 BCBSTX considers to be Experimental/Investigational.

Benefits for Treatment of Acquired Brain Injury

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:

- 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, including outpatient day treatment or other post-acute care treatment;
- 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;
- Neurocognitive rehabilitation - Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy - Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy - Services that utilizes operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;

- Neurophysiological testing - An evaluation of the functions of the nervous system;
- Neurophysiological treatment - Interventions that focus on the functions of the nervous system;
- Neuropsychological testing - The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment - Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Post-acute transition services - Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration, including outpatient day treatment or other post-acute care treatment. This will include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under the Pre-65 Retiree Medical Plan who:
    1. has incurred an Acquired Brain Injury;
    2. has been unresponsive to treatment; and
    3. becomes responsive to treatment at a later date.
- Psychophysiological testing - An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment - Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- 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.

Treatment for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute rehabilitation hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Benefits for Treatment of 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, as defined below, will include but not be limited to the following:

a. Diabetes Equipment

1). Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
2). 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

3). Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. Diabetes Supplies

1). Test strips specified for use with a corresponding blood glucose monitor,
2). Visual reading and urine test strips and tablets for glucose, ketones, and protein,
3). Lancets and lancet devices,
4). Insulin and insulin analog preparations,
5). Injection aids, including devices used to assist with insulin injection and needleless systems,
6). Biohazard disposable containers,
7). Insulin syringes,
8). Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
9). Glucagon emergency kits.

c. 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 will exceed the purchase price of a similar replacement pump.

d. 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.

e. 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:

1). The physical cause and process of diabetes;
2). Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
3). Prevention and treatment of special health problems for the diabetic patient;
4). Adjustment to lifestyle modifications; and
5). Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

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 the Pre-65 Retiree Medical 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.

Benefits for Physical Medicine Services

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 Schedule of Coverage.

All benefit payments made by BCBSTX for Physical Medicine Services, whether under the In-Network, Out-of-Network, or Out-of-Area Benefits level, will apply toward the benefit visit maximum amount shown on your Schedule of Coverage.

Benefits for Chiropractic Services

Benefits for Medical-Surgical Expenses incurred for Chiropractic Services are available as shown on your Schedule of Coverage. All benefit payments made by BCBSTX for Chiropractic Services, whether under the In-Network, Out-of-Network, or Out-of-Area Benefits level, will apply toward the benefit maximum under each level of benefits, if applicable.

Benefits for Other Routine Services

Benefits for other routine services are available for the following as indicated on your Schedule of Coverage:

- x-rays;
- annual hearing examinations, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment;*** and
- annual vision examinations.

Benefits for Preventive Care Services:

Preventive care services will be provided for the following covered services:

a. 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"**);
b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (**"CDC"**) with respect to the individual involved;
c. 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
d. Depression screening, annual screening and counseling for interpersonal and domestic violence; and
e. with respect to women, such additional preventive care and screenings 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 described in items a. through e. 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, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, healthy diet 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.

Preventive care services provided by an In-Network Provider for the items a. through e. above will not be subject to Out-of-Pocket, Deductible, Copayment and/or dollar maximums.

Covered services not included in items a. through e. above may be subject to Out-of-Pocket, Deductible, Copayment and/or dollar maximums.

Benefits for Routine Exams and Immunizations

Benefits for routine exams are available for the following Preventive Care Services as indicated on your Schedule of Coverage:

- well-baby care (after the newborn's initial examination and discharge from the Hospital);
- routine annual physical examination, including routine lab and x-ray;
- immunizations.

Benefits for childhood immunizations will be provided as described in Benefits for Childhood Immunizations for children. Benefits are not available for Inpatient Hospital Expense or Medical-Surgical Expenses for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older, as shown in Preventive Care Services on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a Qualified Individual, as defined below, 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 Schedule of Coverage.

Qualified Individual *means:*

a. A postmenopausal woman not receiving estrogen replacement therapy;
b. An individual with:
   - vertebral abnormalities,
   - primary hyperparathyroidism, or
   - a history of bone fractures; or
c. 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.

Benefits for Tests for 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 Schedule of Coverage.

Benefits for Certain Tests for 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 Pre-65 Retiree Medical 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 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.

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available, as shown in ***Preventive Care Services*** on your 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 Pre-65 Retiree Medical 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.

Benefits for 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 Out-of-Pocket Maximum will not be applicable, as shown in ***Preventive Care Services*** on your 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.

Benefits for Morbid Obesity

Benefits are available for healthy diet counseling and obesity screening/counseling as shown in ***Preventive Care Services*** on your Schedule of Coverage.

Behavioral Health Services

Benefits for Treatment of Chemical Dependency

Benefits for Eligible Expenses incurred for the treatment of Chemical Dependency will be the same as for treatment of any other sickness. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

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.

Benefits for Treatment of Serious Mental Illness

Benefits for Eligible Expenses incurred for the treatment of Serious Mental Illness will be the same as for treatment of any other sickness. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection 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 treatment of Serious Mental Illness in lieu of inpatient hospital services will, for the purpose of this benefit, be considered **Inpatient Hospital Expenses.**

Benefits for Mental Health Care

Benefits for Eligible Expenses incurred for Mental Health Care will be the same as for treatment of any other sickness. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection 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 in lieu of inpatient hospital services will, for the purpose of this benefit, be considered **Inpatient Hospital Expenses**.

Medical Benefit Limitations and Exclusions

The Pre-65 medical benefits as described in this SPD are not available for:

1. 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.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by BCBSTX.
4. 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.
5. 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 will 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.
6. 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.
7. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
8. 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.
9. 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.
10. 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.
11. 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.
12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Pre-65 Retiree Medical Plan for:
    - ***Preventive Care Services*** as shown on your 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 **Special Provisions Expenses**.

13. Any services or supplies provided for Custodial Care.
14. 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.
15. Any items of Medical-Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances.
16. 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 this SPD.
17. 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 will 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, except as may be provided under the ***Benefits for Speech and Hearing*** provisions in the **Special Provisions Expenses** portion of this SPD.
18. 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.
19. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and opposition disorders.
20. 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,.
21. 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.
22. 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.
23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
24. Any services or supplies provided for, in preparation for, or in conjunction with:
    - Sterilization reversal (male or female);
    - Transsexual surgery;
    - Sexual dysfunctions; 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.

25. 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.
26. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.
27. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
28. Supplies for smoking cessation programs and the treatment of nicotine addiction.
29. Any services or supplies provided for the following treatment modalities:
    - acupuncture;
    - intersegmental traction;
    - surface EMGs;
    - spinal manipulation under anesthesia; and
    - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
30. Any services or supplies furnished under the In-Network or Out-of-Network portions of the Pre-65 Retiree Medical Plan by a Network 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.
31. 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.
32. Any benefits in excess of any specified dollar, day/visit or Calendar Year.
33. 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.
34. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under the Pre-65 Retiree Medical Plan.
35. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.
36. Private duty nursing services, except for covered Extended Care Expenses.
37. Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase other than injectable drugs administered by or under the direct supervision of a Physician or Professional Other Provider.
38. Any services or supplies provided for reduction mammoplasty.
39. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under Preventive Care Services.
40. Any services or supplies not specifically defined as Eligible Expenses in the Pre-65 Retiree Medical Plan.
41. Benefits for In Vitro Fertilization.

Note: Notwithstanding the foregoing, in certain circumstances, for reasons such as overall cost savings or medical treatment efficiency, the Pre-65 Retiree Medical Plan may, in the sole discretion of the Plan Administrator, provide benefits for services that would otherwise not be

eligible expenses. The fact that the Pre-65 Retiree Medical Plan does so in any particular case will not in any way be deemed to require the Pre-65 Retiree Medical Plan to do so in other similar cases.

PHARMACY BENEFITS

This portion of the Pre-65 Retiree Medical Plan provides coverage for Medically Necessary Covered Drugs prescribed to treat a Participant for a chronic, disabling, or life-threatening illness covered under the Pre-65 Retiree Medical Plan 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 FDA, such drugs, unless the intended use is specifically excluded under the Pre-65 Retiree Medical Plan, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names. In such cases, the Prescription Drug benefit may be limited to only one of the brand equivalents available. Benefits are available for Covered Drugs as indicated on your Schedule of Coverage.

How the Programs Work

When you need a Prescription Order filled, you can elect to go to a Participating Pharmacy or use the mail-order program. **Please note:** Some Medicare Part B supplies may not be available at retail pharmacies or our home delivery pharmacy.

Selecting a Pharmacy

Participating Pharmacy

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 Copayment 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 Allowable Amount as determined by BCBSTX or EnvisionRX, as applicable, or
- other contractually determined payment amounts.

You are responsible for paying any, Copayment Amounts and any pricing differences, when applicable. You may be required to pay for limited or non-covered services. No claim forms are required.

If you are unsure whether a Pharmacy is a Participating Pharmacy, you may access the website at www.bcbstx.com or www.envisionrx.com, as applicable, or contact the appropriate Customer Service Helpline shown in this SPD or on your Identification Card.

All Participating Pharmacies can provide you with a one-month or up to a 30-day supply of your prescription.

Mail-Order Program

The mail-order program provides delivery of Covered Drugs directly to your home address. If you and your covered Dependents elect to use the mail-order service, refer to your Schedule of Coverage for applicable payment levels.

Some drugs may not be available through the mail-order program, including Medicare Part B medications. If you have any questions about this mail-order program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the website at www.envsionrx.com or contact the 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.

If you send an incorrect payment amount for the Covered Drug dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

Specialty Drugs

The Pre-65 Retiree Medical Plan requires that all drugs listed on the EnvisionRX Standard Specialty Drug List be dispensed through the specialty prescription drug program by EnvisionRX. The specialty drug day supply will be a 30 day supply.

Injectable Drugs

Injectable drugs approved by the FDA for self-administration are covered under the Pre-65 Retiree Medical Plan. You are responsible for any Copayment Amounts and pricing differences that may apply to the Covered Drug dispensed. Injectable drugs include, but are not limited to, insulin and Imitrex.

The day supply of disposable syringes and needles you will need for self-administered injections will be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per Prescription Order in a 30-day period.

Diabetes Supplies for Treatment of Diabetes

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, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the ***Benefits for Treatment of Diabetes*** section of the medical portion of this SPD), will 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

You are responsible for any Copayment Amounts and any pricing differences that may apply to the items dispensed.

Medication Therapy Management Program

A Medication Therapy Management (MTM) Program is a service that the Pre-65 Retiree Medical Plan may offer. You may be invited to participate in a MTM Program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. If you have questions concerning the MTM Program, please contact the EnvisionRX Customer Service number.

Coverage of Contraception for Women

In accordance with federal guidelines issued for Women's Preventive Services as part of the Affordable Care Act, the Plan provides coverage of the full-range of FDA-approved contraceptive methods at no cost to the member for generics and approved brand names. No-cost contraception applies to women only. No-cost contraception is available in both retail and mail order.

Your Cost

Copayment Amounts

Copayment Amounts for a Participating Pharmacy or the mail-order program are shown on your Schedule of Coverage. The amount you pay depends on whether you are in the Non- and the Covered Drug dispensed. If the Covered Drug dispensed is a:

1. Generic Drug - You pay the Generic Drug Copayment Amount
2. Formulary Brand Name Drug – You pay the Formulary Brand Name Drug Copayment Amount
3. Non-Formulary Brand Name Drug – You pay the Non-Formulary Brand Name Drug Copayment Amount

If the Allowable Amount of the Covered Drug is less than the Copayment Amount, you will pay the lower cost.

How Copayment Amounts Apply

When your authorized Health Care Practitioner has marked the Prescription Order "Brand Necessary" or "Brand Medically Necessary," the pharmacist may *only* dispense the Brand Name Drug and you pay the appropriate Brand Name Drug Copayment Amount.

If the authorized Health Care Practitioner has not stipulated a dispensing directive prohibiting substitution of a generic equivalent (Brand Necessary or Brand Medically Necessary), you may still choose to buy the Brand Name Drug instead of the Generic Drug.

If the Brand Name Drug dispensed is on the *Formulary Brand Name Drug List*, your payment amount will be the sum of:

(a) the Formulary Brand Name Drug Copayment Amount, **plus**
(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the Formulary Brand Name Drug.

If the brand name drug dispensed is a Non-Formulary Brand Name Drug, your payment amount will be the sum of:

(a) the Formulary Brand Name Drug Copayment Amount, **plus**
(b) the difference between the Allowable Amount of the Generic Drug and the Allowable Amount of the Non-Formulary Brand Name Drug.

Out-of-Pocket Maximum

Your Out-of-Pocket Maximum will not include:

- Copayments for medications or supplies limited or excluded by the Pre-65 Retiree Medical Plan;
- Any Covered Drugs paid by the Primary Plan when the Pre-65 Retiree Medical Plan is the Secondary Plan for purposes of coordination of benefits; and
- Penalties applied for failure to dispense the prescription as written.

Individual Out-of-Pocket Maximum

When the Out-of-Pocket Maximum Amount for Covered Drugs under the Pre-65 Retiree Medical Plan for a Participant in a Calendar Year equals the "individual" "Out-of-Pocket Maximum" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the prescription drug benefits available for additional Covered Drugs incurred by that Participant for the remainder of that Calendar Year for that level.

Family Out-of-Pocket Maximum

When the Out-of-Pocket Maximum Amount for Covered Drugs for all Participants under your coverage in a Calendar Year equals the "family" "Out-of-Pocket Maximum" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the prescription drug benefits available for additional Covered Drugs incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family "Out-of-Pocket Maximum."

Copayments will no longer be required for Covered Drugs obtained from a Participating Pharmacy or under the mail-order program after the Out-of-Pocket Maximums are met and the benefit percentages become 100%.

Formulary Drug List

A Formulary Brand Name Drug is subject to the Formulary Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive. These drugs are identified on the *Formulary Drug List* that is maintained by EnvisionRX. EnvisionRX routinely reviews the *Formulary Drug List* and periodically adjust it to modify the Formulary or Non-Formulary Brand Name Drug status of existing or new drugs. The *Formulary Drug List* and any modifications will be made available to Participants. Participants may access the EnvisionRX website at www.envisionrx.com or call the Customer Service Helpline at the telephone number shown in this SPD or on your Identification Card to determine if a particular drug is on the *Formulary Drug List*. Drugs that do not appear on the *Formulary Drug List* may be subject to the Non-Formulary Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive.

Day Supply

Benefits for Covered Drugs obtained from a Participating Pharmacy or through the mail-order program are provided up to the maximum day supply limit as indicated on your Schedule of Coverage. The Copayment Amount applicable for the designated day supply of dispensed drugs is also indicated on your Schedule of Coverage. Payment for benefits covered under this Pre-65 Retiree Medical Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

Quantity Versus Time Limits

The maximum quantity of a given prescription drug indicates the number of units to be dispensed and is determined based on pertinent medical information and clinical efficacy and safety. Quantities of some drugs are restricted regardless of the quantity ordered by the Health Care Practitioner. To determine if a specific drug is subject to this limitation, you may access the website www.envisionrx.com or contact Customer Service at the toll-free number on your Identification Card.

If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, the Prescription Order will only be covered for a clinically appropriate pre-determined quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines. If you require a Prescription Order in excess of the dispensing limit, ask your Health Care Practitioner to submit a request for clinical review on your behalf. The request will be approved or denied after evaluation of the submitted clinical information. Payment for benefits covered by under this Pre-65 Retiree Medical Plan may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum quantity limitation.

Step Therapy Program

Certain Brand Medications Require Use of Another Medication First

For certain medications to be covered by the Pre-65 Retiree Medical Plan, you must try a less expensive, but therapeutically equivalent medication first, before "stepping up" to a more

expensive brand name medication. In most cases, the preferred alternative is a generic, but it may also be a select brand name medication.

Under this Program, when you are first prescribed a medication requiring step therapy, the pharmacist will tell you of the Step Therapy Program requirement. You then have the option to:

- Get the medication as prescribed, but pay the full cost; or
- Contact your doctor (sometimes the pharmacist will do this for you) and get a revised prescription for one of the allowed therapeutically equivalent medications.

Your doctor may submit to the Plan an exception request to step therapy if there is a clinical medical history supporting your need for the brand name medication as prescribed. If an exception is approved by the Pre-65 Retiree Medical Plan, you may get your brand name medication at the Program's specified copayment.

Some types of medications that require you to use a generic first include, but are not limited to:

- Cholesterol medications;
- ;Antidepressants;
- Gout medications;
- Insomnia medications;
- Osteoporosis medications;
- Pain and inflammation medications, such as COX-II inhibitors; and
- Stomach acid medications, such as Proton Pump Inhibitors (PPIs).
- Overactive bladder/incontinence medications such as urinary antispasmodics;

For more information about which medications are subject to the Step Therapy Program, please contact the BCSTX or EnvisionRX Customer Service number. This medication list may change periodically.

Prescription Drug Limitations and Exclusions

Prescription drug benefits are not available for:

1. Drugs which do not by law require a Prescription Order from a Provider (**except** insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels); and drugs or covered devices for which no valid Prescription Order is obtained.
2. 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 (provided that disposable hypodermic needles and syringes for self-administered injections and those devices listed as Diabetes Supplies will be specific exceptions to this exclusion). NOTE: Coverage for contraceptive devices is provided under the medical portion of this Pre-65 Retiree Medical Plan.
3. Administration or injection of any drugs.
4. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative.
5. Drugs dispensed 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.
6. 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.

7. 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 will 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.
8. Any special services provided by the Pharmacy, including but not limited to, counseling and delivery.
9. 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 Pre-65 Retiree Medical Plan.
10. Contraceptive devices, non-prescription contraceptive materials, (**except** prescription contraceptive drugs which are Legend Drugs.) NOTE: Coverage for contraceptive devices is provided under the medical portion of this Pre-65 Retiree Medical Plan.
11. Oral and injectable infertility and fertility medications.
12. 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.
13. Drugs dispensed in quantities in excess of the day supply amounts stipulated in your 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.
14. Legend Drugs which are not approved by the 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.
15. 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.
16. Any drugs 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.
17. Drugs, that the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
18. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
19. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under EPE's group health care plan, or for which benefits have been exhausted.
20. 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.
21. Services and supplies for smoking cessation programs and the treatment of nicotine addiction except that smoking cessation drugs are Covered Drugs. Further, smoking cessation counseling services are covered as preventive care under the medical benefit section of this SPD.

22. Compounded drugs that do not meet the definition of Compound Drugs in this portion of your SPD.
23. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
24. 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 Pre-65 Retiree Medical Plan, at its sole discretion.
25. Athletic performance enhancement drugs.
26. 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.
27. Allergy serum and allergy testing materials.
28. Injectable drugs, except those self-administered subcutaneously.
29. Some equivalent drugs manufactured under multiple brand names. EnvisionRX may limit benefits to only one of the brand equivalents available.

Subrogation

If the Pre-65 Retiree Medical Plan pays or provides benefits for you or your Dependents, the Pre-65 Retiree Medical Plan is automatically subrogated to all rights of recovery which you or your Dependents have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Pre-65 Retiree Medical Plan has paid or provided. That means the Pre-65 Retiree Medical Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer (**"third party"**). By participating in the Pre-65 Retiree Medical Plan, your and your Dependents each agree to be bound by these subrogation provisions. State law doctrines and rules, such as the "make whole" doctrine, the "anti-assignment" rule, or any other state law or rule, will not prevent the Pre-65 Retiree Medical Plan from recovering 100% of its payments from the proceeds of the recovery.

You or your Dependent (or legal representative or estate) must notify the Plan Administrator of any claim or lawsuit against a third party or insurance carrier within 30 days of the date that the claim is made or the lawsuit is filed. The Plan Administrator, on behalf of the Pre-65 Retiree Medical Plan, also has the right to pursue any action to enforce its subrogation rights against a third party or insurance carrier.

Agreement To Subrogation And Reimbursement

You and your Dependents by accepting any benefits under the Pre-65 Retiree Medical Plan consent and agree:

- That the Pre-65 Retiree Medical Plan will be promptly reimbursed for 100% of the payments made to or on your or your Dependent's behalf out of the first monies recovered as a result of any lawsuit, judgment, order, award, settlement, compromise, arbitration or other arrangement (regardless of whether there has been a full recovery or such sums are allocated to any particular type of loss, damage or expense and regardless of whether you or your Dependent has been fully compensated for his losses or "made whole"); and
- To include all benefits paid or payable under the Pre-65 Retiree Medical Plan in any liability or other claim against a third party or its insurance carrier. Furthermore, you and your Dependents promise and agree to take such action, to furnish such information and assistance, to execute and deliver any assignments, subrogation and reimbursement agreements, and other instruments as the Plan Administrator or its agent may require to facilitate enforcement of the Pre-65 Retiree Medical Plan's subrogation rights, and not to

prejudice, or in any way detrimentally affect, such rights. The Pre-65 Retiree Medical Plan's rights will not be affected by any release, including a partial release that is entered into without the consent of the Plan Administrator.

The Pre-65 Retiree Medical Plan's subrogation and reimbursement rights will extend to:

- All conceivable sources of recovery, other than the Pre-65 Retiree Medical Plan itself, including, by way of example and not limitation, any and all automobile insurance coverage (including uninsured/underinsured motorist coverage), no-fault coverage, medical insurance coverage, school insurance coverage, disability coverage, personal injury awards or settlements, and medical malpractice awards or settlements; and
- All types of payments made by or on behalf of a third party, regardless of how designated, including without limitation, payments for medical expenses, disability, accidental death or dismemberment, past or future wages or loss of earnings capacity, pain and suffering, mental anguish, loss of consortium or companionship, and exemplary damages of any kind. For purposes of clarity and not limitation, to the extent that a recovery from a third party is obtained by an attorney for you or your Dependent, the full amount that the Pre-65 Retiree Medical Plan is entitled to recover will not be offset or otherwise reduced by any attorney's fees or other costs of recovery that were not specifically approved in advance in writing by the Plan Administrator or its designated agent.

Subrogation And Reimbursement Rights Not Affected By Payment Limitation

The Pre-65 Retiree Medical Plan's subrogation and reimbursement rights:

- Will extend only to the recovery by the Pre-65 Retiree Medical Plan of the benefits that it has paid or will pay to or on behalf of your or your Dependent and the cost of prosecuting the claim for recovery, including reasonable attorney's fees and court and collection costs; and
- Will fully apply and control even if you or your Dependent has only received a partial recovery from a third party.

Subrogation And Reimbursement Rights Not Affected By Payment

The Pre-65 Retiree Medical Plan's subrogation and reimbursement rights will not be affected if benefits are paid under the Pre-65 Retiree Medical Plan before the Plan Administrator or its agent obtains any additional agreements from your or your Dependent (or from any other payee) or if the Plan Administrator does not request any such agreement. In addition, the failure or refusal of your or your Dependent (or other payee, if applicable) to sign an agreement at the request of the Plan Administrator or its agent recognizing the Pre-65 Retiree Medical Plan's subrogation and reimbursement rights may result in a forfeiture of all benefits payable to your or your Dependent (or other payee), as determined by the Plan Administrator, even if such benefits have already been paid. The Plan Administrator will retain a right to recover paid benefits which are forfeited in such a manner; moreover, any such failure or refusal will not affect the Pre-65 Retiree Medical Plan's rights which will remain in full force and effect.

Lien On Proceeds

The Plan Administrator, on behalf of the Pre-65 Retiree Medical Plan, will have a first and primary equitable lien against the proceeds of any settlement, award or judgment that result from a claim, lawsuit or other action by or on behalf of your or your Dependent who received benefits under the Pre-65 Retiree Medical Plan. Notice of the lien is sufficient to establish the Pre-65 Retiree Medical Plan's lien against the third party or insurance carrier. The Plan Administrator will be entitled to:

- Deduct the amount of the lien from any future claims payable to or on behalf of your or your Dependent if:
  - The lien is not repaid or otherwise recovered by the Plan Administrator; or
  - Your or your Dependent fails to promptly notify the Plan Administrator of such a payment received from a third party or insurance carrier that is subject to the Pre-65 Retiree Medical Plan's subrogation and reimbursement rights.
- To otherwise take any action that the Plan Administrator deems necessary or appropriate, in its discretion, to enforce the Pre-65 Retiree Medical Plan's rights to automatic equitable subrogation lien and reimbursement rights to the full extent permitted by law.

Right of Reimbursement

In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, the Pre-65 Retiree Medical Plan will have a right of reimbursement.

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Pre-65 Retiree Medical Plan paid benefits, you or your Dependent agree to reimburse the Pre-65 Retiree Medical Plan from the recovered money for the amount of benefits paid or provided by the Pre-65 Retiree Medical Plan. That means you or your Dependent will pay to the Pre-65 Retiree Medical Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Pre-65 Retiree Medical Plan.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Pre-65 Retiree Medical Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Pre-65 Retiree Medical Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Plan Administrator before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Pre-65 Retiree Medical Plan to be limited or harmed by any acts or failure to act on your part.

Right To Receive And Release Necessary Information

For the purposes of determining the applicability of and implementing these subrogation and reimbursement provisions, the Plan Administrator may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator deems to be necessary for such purposes, with respect to any person claiming benefits under this Pre-65 Retiree Medical Plan. You and your Dependents agree to provide the Plan Administrator such information as may be necessary to implement this provision.

If it becomes necessary for the Pre-65 Retiree Medical Plan to enforce the subrogation and reimbursement provisions by initiating any action against you or your Dependent, your or your Dependent agrees to pay the Pre-65 Retiree Medical Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If your or your Dependent take no action to recover money from any source, then you or your Dependent agrees to allow the Pre-65 Retiree Medical Plan to initiate its own direct action for such recovery.

Coordination of Benefits

The availability of benefits specified in this Pre-65 Retiree Medical Plan (referred to in this section as "**This Plan**") is subject to Coordination of Benefits ("**COB**") as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan will not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group-type coverage, whether insured or uninsured. This includes:
   a. group or blanket insurance;
   b. franchise insurance that terminates upon cessation of employment;
   c. group hospital or medical service plans and other group prepayment coverage;
   d. any coverage under labor-management trustee arrangements, union welfare arrangements, or employer organization arrangements;
   e. governmental plans, or coverage required or provided by law.

Plan does not include:

   a. 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;
   b. a policy of health insurance that is individually underwritten and individually issued;
   c. school accident type coverage; or
   d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the Pre-65 Retiree Medical Plan described in this SPD.

3. **Primary Plan/Secondary Plan**. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. *A Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Medicare.** Special rules apply when you are covered by this Pre-65 Retiree Medical Plan and by Medicare. Generally, if you qualify for Medicare by reason of age or disability you will be eligible for the Post-65 Retiree Medical Plan. However, in the limited circumstances where you remain eligible for this Pre-65 Retiree Medical Plan (i.e., when you have end-stage renal disease), this plan is secondary to Medicare (i.e., Medicare is the Primary Plan) after a period of 30 months. For the first 30 months the Pre-65 Retiree Medical Plan is primary to Medicare.

   Coordination of Benefits with Medicare
   While the prescription drug benefits offered under the Pre-65 Retiree Medical Plan constitute Creditable Coverage for purposes of Medicare Part D, so that you do not have to enroll in a Medicare Part D prescription drug program, the other benefits offered under the Pre-65 Retiree Medical Plan coordinate with Medicare.

   When you or a covered Dependent become eligible for Medicare Part A and/or Part B (collectively "**Medicare**") on end stage renal disease, benefits payable under this Pre-65 Retiree Medical Plan will be coordinated with Medicare regardless whether you or your covered Dependent have applied for and been granted coverage under Medicare. That means that if you or a covered Dependent are eligible for Medicare by reason of end stage renal disease, but do not enroll and you incur medical expenses, the Pre-65 Retiree Medical Plan will pay benefits after determining what Medicare would have paid/covered had you actually been enrolled for benefits under Medicare and you will be responsible for the difference between what the Pre-65 Retiree Medical Plan pays and what Medicare would have paid. Accordingly, in order to ensure you obtain the maximum benefit from the Pre-65 Retiree Medical Plan, you and your covered Dependents who are eligible for Medicare by reason end stage renal disease are encouraged to apply for and obtain coverage under Medicare as soon as you are eligible.

   If you or a covered Dependent are entitled to Medicare by reason of end-state renal disease, the benefits under the Pre-65 Retiree Medical Plan will be primary for an initial period of 30 months.

5. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.

5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We or Us** means BCBSTX or EnvisionRX, as applicable.

Order of Benefit Determination Rules

1. **General Information**
   a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan,

unless (a) the other Plan has rules coordinating its benefits with those of this Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

b. If this SPD contains any dental or vision benefits, the benefits provided by the health portion of This Plan will be the Secondary Plan.

2. **Rules**. This Plan determines its order of benefits using the first of the following rules which applies:

a. ***Non-Dependent/Dependent***. The benefits of the Plan which covers the Participant as a retired employee, member or subscriber are determined before those of the Plan which covers the Participant as a dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
   (1) secondary to the Plan covering the Participant as a dependent and
   (2) primary to the Plan covering the Participant as other than a dependent (e.g., a retired employee), then the benefits of the Plan covering the Participant as a dependent are determined before those of the Plan covering that Participant other than a dependent.

b. ***Dependent Child/Parents Not Separated or Divorced***. Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a dependent of different parents:
   (1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but
   (2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. ***Dependent Child/Parents Separated or Divorced***. If two or more Plans cover a Participant as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
   (1) First, the Plan of the parent with custody of the child;
   (2) Then, the Plan of the spouse of the parent with custody, if applicable;
   (3) Finally, the Plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

a. ***Joint Custody.*** If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the

health care expenses of the child, the Plans covering the child will follow the order of benefit determination rules outlined in Paragraph b.

b. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired employee. The same would hold true if a Participant is a Dependent of a person covered as a retired employee and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following will be the order of benefit determination:
(1) First, the benefits of a Plan covering the Participant as an employee, member or subscriber (or as that Participant's dependent);
(2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage***. If none of the above rules determine the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. **When This Section Applies.** This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.
2. **Reduction in this Plan's Benefits.** The benefits of This Plan will be reduced when the sum of:
   a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
   b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses. When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person

claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

DEFINITIONS

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 BCBSTX or EnvisionRX, as applicable, to be eligible for consideration of payment under the Pre-65 Retiree Medical Plan for a particular drug, service, supply, or procedure.

- ***For Prescription Drugs*** – The Allowable Amount means the maximum amount determined by EnvisionRX to be eligible for consideration of payment for a particular Covered Drug. (i) As applied to Participating Pharmacies and the mail-order program, the Allowable Amount is based on the provisions of the contract between EnvisionRX and the Participating Pharmacy or Pharmacy for the mail-order program in effect on the date of service. (ii) As applied to non-Participating Pharmacies, the Allowable Amount is based on the Participating Pharmacy contract rate.

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with BCBSTX or any other Blue Cross and Blue Shield Plan*** – The 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 BCBSTX*** - The 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 BCBSTX. Such factor will be not less than 75% 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 BCBSTX. Such factor will not be less than 75% and will 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 BCBSTX. Such factor will not be less than 75% and will be updated not less than every two years.

BCBSTX 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 BCBSTX does not have any claim edits or rules, BCBSTX 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 BCBSTX 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 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.

Autism Spectrum Disorder means a *neurobiological disorder* that includes autism, Asperger's syndrome, or pervasive development disorder-not otherwise specified. A neurobiological disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors. Benefits for Autism Spectrum Disorder are determined on the same basis as any other mental or physical condition.

BCBSTX means Blue Cross and Blue Shield of Texas who serves as the Claims Administrator of the medical benefits provided under the Pre-65 Retiree Medical Plan.

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency under the Pre-65 Retiree Medical Plan, only as listed in this SPD.

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)
- Ultrasound

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:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or
4. 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 services or supplies provided by or under the direction of a Doctor of Chiropractic.

Claim Administrator means BCBSTX with respect to the medical benefits provided under the Pre-65 Retiree Medical Plan, and EnvisionRX for the prescription drug coverage provided under the Pre-65 Retiree Medical Plan.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
5. 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:

1. 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 will 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
2. 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.

Compound Drugs mean those drugs that have been measured and mixed with FDA approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form. The drugs used must meet the following requirements:

1. The drugs in the compounded product are FDA approved;
2. The approved product has an assigned National Drug Code (NDC); and
3. The primary active ingredient is a Covered Drug under the Pre-65 Retiree Medical Plan.
4. The drugs do not include ingredients that have no clinical value when turned into a compounded product.

Copayment Amount means with respect to medical benefits, 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 and with respect to prescription drug benefits, the dollar amount paid by the Participant for each Prescription Order filled or refilled through a Participating Pharmacy.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Drugs means any Legend Drug (including insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, with disposable syringes and needles needed for self-administration):

1. Which is Medically Necessary and is ordered by an authorized Health Care Practitioner naming a Participant as the recipient;
2. For which a written or verbal Prescription Order is provided by an authorized Health Care Practitioner;
3. For which a separate charge is customarily made;
4. Which is not entirely consumed at the time and place that the Prescription Order is written;
5. For which the FDA has given approval for at least one indication; and

6. Which is dispensed by a Pharmacy and is received by the Participant while covered under the Pre-65 Retiree Medical Plan, **except when** received from a Provider's office, or during confinement while a patient in a hospital or other acute care institution or facility (refer to **Limitations and Exclusions**).

Creditable Coverage means coverage provided under:

1. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with ERISA;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
   a. group health insurance coverage;
   b. individual health insurance coverage; and
   c. short-term, limited-duration insurance;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, United States Code (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or
11. Title XXI of the Social Security Act (State Children's Health Insurance Program or SCHIP).

Creditable Coverage does not include:

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit-only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (**"FSAs"**) if they meet the definition of a health FSA in section 106(c)(2) of the Internal Revenue Code and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;

11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (also known as TRICARE supplemental programs); and
14. Similar supplemental coverage provided to coverage under a group health plan.

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 will 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 Pre-65 Retiree Medical Plan will be available.

Dependent means your Spouse or a Child covered under the Pre-65 Retiree Medical Plan who is:

1. Under age 26;
2. A Child of any age who is medically certified as disabled and dependent on the parent for support and maintenance (provided they were covered before reaching age 26).

Child means any of the following individuals as of the date you become a Retired Employee or Disabled Employee:

c. Your natural child; or
d. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought;
e. Your stepchild; or
f. Your child for whom you have been awarded legal custody.

Children you acquire after the date you become a Retired Employee or Disabled Employee will not qualify as a Child under this Pre-65 Retiree Medical Plan and will not be eligible for enrollment.

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

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Disabled Employee means an Employee who has attained age 41 and completed at least 24 years of "Vesting Service" as that term is defined in the Retirement Plan with EPE and whose termination of employment with EPE was in connection with the Employee's being determined to be disabled pursuant to the terms of any, then in place, group long term disability policy

sponsored by EPE, or if no such policy is currently in place, the Employee's being determined to be disabled within the meaning of the Social Security Act.

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.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligibility Date means the date the Participant satisfies the definition of either "Retired Employee," "Disabled Employee," or "Dependent" and is in a class eligible for coverage under the Pre-65 Retiree Medical Plan as described in the **WHO GETS BENEFITS** section of this SPD.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses covered under the Pre-65 Retiree Medical Plan, as described in this SPD.

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:

1. placing the patient's health in serious jeopardy;
2. serious impairment of bodily functions;
3. serious dysfunction of any bodily organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Employee means a person who:

1. Regularly provides personal services at the Employee's usual and customary place of employment with EPE; and
2. Is recorded as an Employee on the payroll records of EPE; and
3. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

The term Employee will not include any individual who is employed by the employer as a leased employee or independent contractor and who is subsequently determined by EPE, the Internal Revenue Service, the Department of Labor or a court of competent jurisdiction to be a common law employee of EPE. The term Employee also excludes any employee covered by a collective bargaining agreement if benefits were the subject of good faith bargaining and EPE and such collective bargaining representative have not bargained that the unit will be covered by the Employee Medical Plan.

Employee Medical Plan means the medical and prescription drug benefits provided to active employees and their dependents under the Employee Welfare Benefits Plan.

Employee Welfare Benefits Plan means the El Paso Electric Corporation Welfare Benefits Plan.

Environmental Sensitivity means the inpatient or outpatient treatment of allergic symptoms by:

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non-organic, non-repetitive diet techniques.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

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.

BCBSTX will 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, BCBSTX 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.

EnvisionRX means EnvisionRX who serves as the Claims Administrator of the prescription drug benefits provided under the Pre-65 Retiree Medical Plan.

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 this SPD.

Formulary Brand Name Drug means a brand name prescription drug product that is identified on the *Formulary Drug List* and is subject to the Formulary Brand Name Drug Copayment. This list is available by accessing the website at www.envisionrx.com.

Generic Drug means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the

brand or generic classification for Covered Drugs and corresponding Participant Copayment responsibility, EnvisionRX utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information.

Generic Drug Copayment Amount means the Copayment Amount applicable if a Generic Drug is dispensed.

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.

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 be certified by Medicare as a supplier of Home Health Care.

Home Health Care means the health care services for which benefits are provided 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 will include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. 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:

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

Hospice Care means services for which benefits are provided 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:

1. 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;
2. 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;
3. 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;
4. Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
5. Has in effect a Hospital Utilization Review Plan; and
6. 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, will 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 will 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.

Legend Drugs means drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

Identification Card means the card issued to the Participant under the Pre-65 Retiree Medical Plan indicating pertinent information applicable to his coverage.

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.

In-Network Medical Benefits means the benefits available under the Pre-65 Retiree Medical 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:

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

An expense will be deemed to have been incurred on the date of provision of the service for which the charge is made.

Inpatient Hospital Expense will include:

1. 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.
2. 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, will be Inpatient Hospital Expense.

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:

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and
2. 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:

1. Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Pre-65 Retiree Medical 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:

1. Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
3. Billed to the patient by the directing Physician, Behavioral Health Practitioner or Professional Other Provider.

An expense will 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 Pre-65 Retiree Medical Plan which are:

1. 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
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
4. 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 will determine whether a service or supply is Medically Necessary 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.

Mental Health Care means any one or more of the following:

1. 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;
2. 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:
   a. Individual, group, family, or conjoint psychotherapy,
   b. Counseling,
   c. Psychoanalysis,
   d. Psychological testing and assessment,
   e. The administration or monitoring of psychotropic drugs, or
   f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

National Drug Code (NDC) means a national classification system for the identification of drugs.

Network 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 Pre-65 Retiree Medical Plan. A Network Facility will 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 Pre-65 Retiree Medical Plan will be deemed a Non-Network Facility regardless of the existence of a written contract with another Blue Cross Plan.

Non-Formulary Brand Name Drug means a Brand Name Drug which does not appear on the *Formulary Drug List* and is subject to the Non-Formulary Brand Name Drug Copayment. This *Formulary Drug List* is available by accessing the website at www.envisionrx.com.

Non-Network 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 Pre-65 Retiree Medical 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-Network Facility.

Open Enrollment Period means the period preceding the next Plan Anniversary Date during which Retired Employees and Disabled Employees may modify their medical and prescription drug coverage and drop Dependents from coverage.

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 will include:

1. **Facility Other Provider** - an institution or entity, only as listed:
   a. Chemical Dependency Treatment Center
   b. Crisis Stabilization Unit or Facility
   c. Durable Medical Equipment Provider
   d. Home Health Agency
   e. Home Infusion Therapy Provider
   f. Hospice
   g. Imaging Center
   h. Independent Laboratory
   i. Prosthetics/Orthotics Provider
   j. Psychiatric Day Treatment Facility
   k. Renal Dialysis Center
   l. Residential Treatment Center for Children and Adolescents
   m. Skilled Nursing Facility
   n. Therapeutic Center

2. **Professional Other Provider** - a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
   a. Advanced Practice Nurse
   b. Doctor of Chiropractic

c. Doctor of Dentistry
d. Doctor of Optometry
e. Doctor of Podiatry
f. Doctor in Psychology
g. Licensed Acupuncturist
h. Licensed Audiologist
i. Licensed Chemical Dependency Counselor
j. Licensed Dietitian
k. Licensed Hearing Instrument Fitter and Dispenser
l. Licensed Marriage and Family Therapist
m. Licensed Clinical Social Worker
n. Licensed Occupational Therapist
o. Licensed Physical Therapist
p. Licensed Professional Counselor
q. Licensed Speech-Language Pathologist
r. Licensed Surgical Assistant
s. Nurse First Assistant
t. Physician Assistant
u. 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 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 Medical Benefits means the benefits available 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 the dollar amount of Eligible Expenses including Deductible and Copayment Amounts incurred by a Participant during a Calendar Year that exceeds benefits provided under the Pre-65 Retiree Medical Plan. Separate Out-of-Pocket Maximums apply to the medical benefits and the prescriptions drug benefits provided under the Pre-65 Retiree Medical Plan. Refer to **Out-of-Pocket Maximum** in **ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND MEDICAL BENEFITS** of the SPD for additional information.

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 a Retired Employee or Disabled Employee or Dependent whose coverage has become effective under this Pre-65 Retiree Medical Plan.

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty drug Pharmacy which has entered into an agreement to provide pharmaceutical services to Participants under the Pre-65 Retiree Medical Plan.

Pharmacy means a state and federally licensed establishment where the practice of pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

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.

Plan Administrator means the Benefits Oversight Committee of EPE or other named administrator of the Pre-65 Retiree Medical Plan having fiduciary responsibility for its operation. BCBSTX and EnvisionRX are not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this SPD is in force.

Plan Effective Date means the effective date on the Pre-65 Retiree Medical Plan coverage described in this SPD which is January 1, 2018.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

Post-65 Retiree Medical Plan means the program of medical and prescription drug benefits provided under the Plan for Participants who have attained age 65 as described in this SPD.

Preauthorization means the process that determines in advance the Medical Necessity or Experimental/Investigational nature of certain care and services under the Pre-65 Retiree Medical Plan.

Pre-existing Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the 3 months before the effective date of coverage.

Prescription Order means a written or verbal order from an authorized Health Care Practitioner to a pharmacist for a drug or device to be dispensed. Orders written by an authorized Health

Care Practitioner located outside the United States to be dispensed in the United States are not covered under the Pre-65 Retiree Medical Plan.

Pre-65 Retiree Medical Benefit Plan means the medical and prescription drug benefits provided under the Plan for Participants who have not attained age 65 the terms of which are described in this SPD.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. 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
3. 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.

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.

Retired Employee means an Employee of EPE who

1. is covered under the Employee Medical Plan and voluntarily terminates employment with EPE on or after attaining at least age 55 and completing at least 5 years of "Vesting Service," as that term is defined in the Retirement Plan, before such termination of employment, and
2. elects to commence benefits or receive a lump sum distribution of benefits under the Retirement Plan at the time of such termination of employment.

Retiree Welfare Plan means the El Paso Electric Corporation Retiree Welfare Benefits Plan which provides the medical and prescription drug benefits described in this SPD.

Retirement Plan means the Retirement Income Plan for Employees of El Paso Electric Company.

Serious Mental Illness means the following psychiatric illnesses defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):*

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); and
7. Schizophrenia.

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

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

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.

Specialty Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a Specialty Care Provider.

Spouse means your legal spouse including a same sex spouse, except that such term will not include (i) a spouse who is a Retired or Disabled Employee, or (ii) a common law spouse unless you have filed a Declaration and Registration of Informal Marriage with the County Clerk and provided a copy of the same to the Plan Administrator. If you marry or remarry after you become a Retired Employee or Disabled Employee your new spouse will not qualify as a Spouse under this Pre-65 Retiree Medical Plan and will not be eligible for enrollment.

Surviving Spouse means your Spouse who is married to you on the date of your death and a Participant in the Employee Medical Plan, Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan and whose coverage continues under the Pre-65 Retiree Medical Plan or Post-65 Retiree Medical Plan.

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

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Who Files Claims

Medical Claims

The Claims Administrator must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits. Network Providers and some other health care Providers (such as ParPlan Providers) will submit your medical claims directly to the Claims Administrator for services provided to you. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

- ***Network Providers*** .When you receive medical treatment or care from a Network Provider, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

- ***Non-Network Providers.*** When you receive medical treatment or care from a Non-Network Provider, 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, refer to the subsection entitled ***Participant- filed claims*** below for instruction on how to file your own claim forms.

- ***Participant- filed Medical claims.*** If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a claim form provided by the Pre-65 Retiree Medical Plan. EPE should have a supply of claim forms or you can obtain copies from the Claims Administrator's 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.

Prescription Drug Claims

- ***Participating Pharmacy Claims.*** When you receive Covered Drugs from a Participating Pharmacy, you will not be required to file claim forms. You are responsible for paying any Copayment Amounts and any pricing differences, when applicable. You may be required to pay for limited or non-covered items.

  Also, if you elect to use a Participating Pharmacy and pay the claim in full, you may submit a request for reimbursement from the Plan using a *Prescription Claim Form.* This form can be obtained from EnvisionRX or the Plan Administrator. This 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.

- ***Mail-Order Program.*** When you receive Covered Drugs dispensed through the mail-order program, you must complete and submit the mail service prescription drug claim form to the address on the claim form. Additional information may be obtained from the Plan Administrator, EnvisionRX, off of the EnvisionRX website, or by calling the EnvisionRX Customer Service Helpline, at 1- 800-595-8531.

  You may not fill a Medicare Part B medication, such as diabetes testing supplies, respiratory medications and supplies, immunosuppressive medications, anti-cancer medications, and anti-nausea medications, through the mail-order program and in most cases will need to fill such prescriptions as a Participating Pharmacy claim. **Please note:** Some Medicare Part B supplies may not be available at retail pharmacies or our home delivery pharmacy.

VISIT THE BCBSTX AND EnvisionRX WEBSITES FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION:

www.bcbstx.com **www.envisionrx.com**

Where to Mail Completed Claim Forms

Medical Claims
Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, TX 75266—0044
1-800-521-2227

Pharmacy Benefit Claims
EnvisionRX
2181 E. Aurora Rd. Suite 201
Twinsburg, OH 44087
1- 800-595-8531

Who Receives Payment

Medical benefit payments will be made directly to contracting Providers when they bill the Claims Administrator. Written agreements between the Claims Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your Surviving Spouse, as beneficiary. If there is no Surviving Spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits**, rights and benefits under the Pre-65 Retiree Medical Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Medical benefits for services provided to your minor Dependent Child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the Child; and
- the Claims Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a Child, the managing or possessory conservator must submit to the Claims Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claims Administrator 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 Pre-65 Retiree Medical Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Retiree Welfare Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for medical benefits under the Pre-65 Retiree Medical Plan must be properly submitted to the Claims Administrator within 12 months of the date you receive the services or supplies. Claims submitted and received by the Claims Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

All claims for pharmacy benefits under the Pre-65 Retiree Medical Plan must be properly submitted to EnvisionRX within 365 days of the date you receive the services or supplies. Claims submitted and received by EnvisionRX after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claim Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Claims Administrator at the address set forth above in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claims Administrator may contact either you or the Provider or pharmacy, as applicable, for the additional information.

After processing the claim, the Claims Administrator will notify the Participant by way of an Explanation of Benefits summary.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When the Claims Administrator receives a properly submitted claim, it has authority and discretion under the Pre-65 Retiree Medical Plan to interpret and determine benefits in accordance with the plan provisions. The Claims Administrator will receive and review claims for benefits and will accurately process claims consistent with the terms of the Pre-65 Retiree Medical Plan and administrative practices and procedures established in writing between the Claims Administrator and the Plan Administrator. You have the right to seek and obtain a full and fair review by the Claims Administrator of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in this SPD.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claims Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by the Claims Administrator; then review this SPD to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision. Include your full name, and the group and identification numbers with the request.

If a claim for medical or prescription drug benefits is denied in whole or in part, you will receive a notice from the Claims Administrator within the following time limits:

1. **Concurrent Claims**. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for benefits.

2. **Urgent Care Claims**. For benefit determinations relating to urgent care/expedited clinical appeal (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A benefit determination will be made within 48 hours after the missing information is received.

   An "**urgent care/expedited clinical claim**" is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

3. **Pre-Service Claims**. For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claims Administrator.

   A "**pre-service claim**" is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

4. **Post-Service Claims**. For post-service claims within 30 days after receipt of the claim by the Claims Administrator.

   A "**post-service claim**" is a request for benefits after the service or prescription drug has been rendered or furnished to you. Your request for benefits must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service or prescription drug rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the Claims Administrator may request in connection with services rendered or prescription drug benefit provided to you.

   For post-stabilization care after an Emergency, a determination will be made within the time appropriate to the circumstance not to exceed one hour after the time of request.

If the Claims Administrator determines that special circumstances require an extension of time for processing a non-urgent pre-service or post-service claim, the Claims Administrator will within the initial period for responding to the claim notify you or your authorized representative in writing of the need for an extension, the reason for the extension, and the expected date of decision. In no event will such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension will also specifically describe the missing information, and you will have at least 45 days from receipt of the notice within which to provide the requested information.

If the claim is denied in whole or in part, you will receive a written notice from the Claims Administrator with the following information, if applicable:

- The reasons for determination including the opportunity to request the diagnostic and treatment codes and their meanings;
- A reference to the Pre-65 Retiree Medical Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- The identification of the claim, date of service, health care provider, claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used to deny the claim;
- An explanation of the Claims Administrator internal review/appeals (and how to initiate a review/appeal) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- In the case of a decision based on medical necessity, experimental; treatment or a similar exclusion or limit an explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances;
- In the case of a denial of an urgent care/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Claim Appeal Procedures

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. An authorized representative means a person you authorize, in writing to act on your behalf. The Pre-65 Retiree Medical Plan will also recognize a court order giving a person authority to submit claims on your behalf. In case of a medical claim involving urgent care, a healthcare professional with knowledge of your condition may always act as your authorized

representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

Claim Appeal Procedures – Definitions

An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator or EPE and that treatment is reduced or terminated (other than by amendment or termination of the Pre-65 Retiree Medical Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to nonpayment of premium.

A "**Final Internal Adverse Benefit Determination**" means an Adverse Benefit Determination that has been upheld by the Claims Administrator or EPE at the completion of the internal review/appeal process. The Pre-65 Retiree Medical Plan is not subject to the external review procedures under the Patient Protection and Affordable Care Act.

Urgent Care/Expedited Clinical Appeals or Concurrent Appeals

If your situation meets the definition of an urgent care/expedited clinical appeal or a concurrent appeal, you may be entitled to an appeal on an expedited basis. An **urgent care/expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, the Claims Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an urgent care/expedited pre-service or concurrent appeal, the Claims Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claims Administrator will issue a decision on the appeal within 24 hours after it receives the requested information, but no later than 72 hours after the appeal has been received by the Claims Administrator.

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in this SPD.

If you believe the Claims Administrator incorrectly denied all or part of your benefits, you may have your claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure:

- Within 180 days after you receive notice of a denial or partial denial, you may call or write to the Claims Administrator. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Pre-65 Retiree Medical Plan Medical Claims	*Pre-65 Medical and Prescription Drug Benefit g Benefit Program Prescription Drug Claims*
Claim Review Section Blue Cross and Blue Shield of Texas P. O. Box 660044 Dallas, Texas 75266—0044 1-800-521-2227	***EnvisionRx*** Pharmacy Appeals 2181 E. Aurora Rd., Suite 201 Twinsburg, OH 44087 1-800-595-8531

- You may also designate a representative to act for you in the review procedure as noted above. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claims Administrator may honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of your claim review, you may have the option of presenting evidence and testimony to the Claims Administrator, by phone or in person at a location of the Claims Administrator's choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

  The Claims Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond.

  The appeal determination will be made by a Physician associated or contracted with the Claims Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim. The reviewer will fully and fairly review your claim, taking into account any additional information you submit, and will not give deference to any prior benefits decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to the reviewer will be based on the likelihood that the reviewer will support a denial of benefits.

  Before you or your authorized representative may bring any action to recover benefits you must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Claims Administrator or EPE.

  If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator or call the toll-free Customer Service Helpline number shown in this SPD or on your Identification Card.

Other Appeals

Upon receipt of a non-urgent pre-service appeal, the Claims Administrator will issue a decision on the appeal as soon as practical, but in no event more than 30 days after the appeal has been received by the Claims Administrator.

Upon receipt of a non-urgent post-service appeal, the Claims Administrator will issue a decision on the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claims Administrator.

Notice of Appeal Determination

The Claims Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination. The written notice will include:

1. A reason for the determination including the opportunity to request the diagnostic and treatment codes and their meanings;
2. A reference to the Pre-65 Retiree Medical Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
3. The identification of the claim, date of service, health care provider, claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
4. A statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
5. In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. In the case of a decision based on medical necessity, experimental; treatment or a similar exclusion or limit, an explanation of the scientific or clinical judgment relied on in the determination;
9. A description of the standard that was used in denying the claim and a discussion of the decision; and
10. To the extent deemed necessary, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call the Claims Administrator. If you need assistance with the internal claims and appeals, you may call the number on the back of your ID card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

EXHAUSTION

You will be deemed to have exhausted the internal review process if the Claims Administrator waives the internal review process or the Claims Administrator has failed to comply with the internal claims and appeals process. In such event, you have the right to pursue any available remedies under 502(a) of ERISA or under State law provided that you do so within two years of your exhaustion or deemed exhaustion of the internal review process.

Interpretation of Pre-65 Retiree Medical Plan Provisions

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the Pre-65 Retiree Medical Plan and the discretion to interpret and determine benefits in accordance with the Pre-65 Retiree Medical Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Pre-65 Retiree Medical Plan.

All powers to be exercised by the Claims Administrator or the Plan Administrator will be exercised in anon-discriminatory manner and will be applied uniformly to assure similar treatment to persons in similar circumstances.

GENERAL PROVISIONS

Amendments

EPE may amend or terminate the Retiree Welfare Plan and the benefits provided under such plan at any time without prior notice to or consent by any Participant. Any material amendment or termination will be communicated to Participants as required by ERISA and will be effective on the date specified in such communication.

Assignment and Payment of Benefits

Rights and benefits under the Retiree Welfare Plan will not be assignable, either before or after services and supplies are provided; provided, that a Participant may direct that benefit payments be made directly to a medical provider. Further, in the absence of a written agreement with a Provider, BCBSTX reserves the right to make benefit payments to the provider or the Retired Employee or Disabled Employee. Payment to either party discharges the Retiree Welfare Plan's responsibility to the Retired Employee or Disabled Employee or Dependents for medical and prescription drug benefits available under the Retiree Welfare Plan. The fact that benefit payment is directed or made directly to the Provider will not give the Provider status as a Participant and any dispute regarding the amount of such payment must be resolved by the Participant through the Retiree Welfare Plan's internal claims procedure (i.e., the Provider may not invoke the internal claims procedure on behalf of the Participant). In addition, once Covered Services have been rendered by a Provider, the Covered Person has no right to request that BCBSTX not pay such provider.

Disclosure Authorization

If you file a claim for medical and prescription drug benefits, it will be necessary that you authorize any health care provider, insurance carrier, or other entity to furnish the Claim Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file a claim for medical

and prescription drug benefits under the Retiree Welfare Plan, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Participant/Provider Relationship

The choice of a health care provider should be made solely by you or your Dependents. The Claim Administrator does not furnish services or supplies but only makes payment for eligible expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any health care provider. The Claim Administrator does not have any responsibility for a health care provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care provider selected and are available only for sickness or injury treatment acceptable to the health care provider.

The Claim Administrator, network providers, and/or other contracting providers are independent contractors with respect to each other. The Claim Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said providers. The Claim Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund of Benefit Payments

If the Claim Administrator pays medical and prescription drug benefits for eligible expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Retiree Welfare Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claim Administrator may deduct any refund due it from any future benefit payment.

Termination of the Plan

The coverage of all Participants will terminate if the Retiree Welfare Plan is terminated by EPE.

COBRA Continuation - Federal

Under the provisions of COBRA, you and/or your covered Dependents may have the right to continue medical and prescription drug coverage under the Retiree Welfare Plan after the date coverage would otherwise end.

Right and Duration of COBRA Continuation Coverage

You may elect to continue medical and prescription drug coverage until your death in the unlikely event EPE is subject of a bankruptcy proceeding under Title 11 of the United States Code.

A covered Spouse may elect to continue coverage:

- for 36 months from the date medical and prescription drug coverage would otherwise cease if coverage under the Retiree Welfare Plan terminates as the result of divorce from the covered Retired Employee or Disabled Employee; or

- in the unlikely event of the bankruptcy of EPE until the earlier of (i) death, or (ii) 36 months from the death of the Covered Retired Employee or Disabled Employee.

A covered Dependent Child may elect to continue coverage:

- for thirty-six (36) months from the date medical and prescription drug coverage would otherwise cease if coverage under the Retiree Welfare Plan terminates as the result of the Child no longer meeting the Dependent eligibility requirements, or
- in the unlikely event of the bankruptcy of EPE until the earlier of (i) death, or (ii) 36 months from the death of the Covered Retired Employee or Covered Disabled Employee.

Termination of COBRA Continuation Coverage

COBRA continuation under the Retiree Welfare Plan ends at the earliest of the following events:

1. The last day of the applicable continuation period (e.g., death or 36 months).
2. The first day for which timely payment of contribution is not made to the Retiree Welfare Plan with respect to the qualified beneficiary.
3. The Retiree Welfare Plan is canceled.
4. The date, after the date of the election, upon which the Participant first becomes covered under any other group health plan that does not contain any pre-existing condition limitation applicable to the Participant.

Notice of COBRA Continuation Rights

EPE is responsible for providing the necessary notification to Participants as required by COBRA. In addition, you are responsible for providing notice to EPE of a loss of medical and prescription drug coverage due to your divorce or loss of Dependent Child status.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this SPD.

Plan Administrator's Powers and Duties

The Retiree Welfare Plan is administered by a Plan Administrator. The Plan Administrator may delegate such duties and responsibilities which in the opinion of the Plan Administrator can be properly supervised.

The Plan Administrator has the duties and powers necessary to carry out its responsibilities under the Plan, including, but in no way limited to:

1. Discretionary authority to construe and interpret the Retiree Welfare Plan, to decide all questions of eligibility, to determine the amount, manner and time of payment of any benefits under the Retiree Welfare Plan, and to resolve any ambiguities with respect to any terms and provisions of the Retiree Welfare Plan, either as written or as applied in the operation of the Retiree Welfare Plan;

2. To prescribe procedures to be followed in an application for benefits;

3. To prepare and distribute information explaining the Retiree Welfare Plan in such a manner as the Plan Administrator determines appropriate;

4. To receive from EPE and covered participants in the Retiree Welfare Plan the information necessary for the proper administration of the Plan;

5. To furnish EPE and covered participants, on request, such annual reports as are reasonable and appropriate with respect to the administration of the Retiree Welfare Plan;

6. To receive, review and keep on file such reports on receipts and disbursements of the Retiree Welfare Plan as the Plan Administrator considers appropriate; and

7. To appoint or employ agents, subcontractors, and representatives to assist in the administration of the Retiree Welfare Plan and such other agents, including claims processors, administrators, accounts, actuaries and legal counsel.

The Plan Administrator will exercise the authority and responsibility that is appropriate in the opinion of the Plan Administrator in order to comply with ERISA and governmental regulations issued thereunder.

The Plan Administrator may act in writing and keep a record of all its acts. All decisions of the Plan Administrator will be made by the Plan administrator or by the duly authorized agents and employees of the Plan Administrator.

Plan Name

The name of the Plan is the El Paso Electric Company Retiree Welfare Benefits Plan. This SPD describes the medical and prescription drug benefits provided under the Pre-65 Retiree Medical Plan provided under the Retiree Welfare Plan.

Plan Number

The plan number used for purposes of filing documents with the Internal Revenue Service is 511.

Plan Sponsor

El Paso Electric Company is the Plan Sponsor and its contact information is as follows:
El Paso Electric Company
P.O. Box 982
El Paso, TX 79960
(915) 543-4116
Tax Identification number: 74-0607870

Plan Administrator

The Benefits Oversight Committee of EPE is the Plan Administrator and its contact information is as follows:
Benefits Oversight Committee
El Paso Electric Company
P.O. Box 982
El Paso, TX 79960
(915) 543-4116

Source of Contributions and Funding Related to Medical and Prescription Drug Benefits

The benefits under the Retiree Welfare Plan are self-funded; however, EPE has established a trust pay benefits. Contributions for medical benefits are determined by EPE and include contributions by you and EPE. Your contributions are based on the level and type of benefit coverages that you elect, and the cost of providing the benefits. These contributions are deposited in the trust. With respect to the benefits, EPE has obtained reinsurance policies with insurance companies for protecting against certain large, unexpected medical claims.

Trustee

The Trustee is Wells Fargo Institutional Retirement and Trust. You may reach the Trustee at the following:
Wells Fargo Institutional Retirement and Trust
MAC T0002-060
1000 Louisiana Street, Suite 630
Houston, TX 77002
(713) 319-1656

Plan Administration

The Retiree Welfare Plan is self-administered by the Plan Administrator. The Plan Administrator has, however, by contract secured the services of BCBSTX and EnvisionRX to serve as Claims Administrator for the purpose of handling certain administrative functions with respect to the medical and prescription drug benefits provided under the Pret-65 Retiree Medical Plan, including the review, processing, and payment of claims. The name address and telephone number of the Claims Administrators for the medical and prescription drug benefits under the Pre-65 Retiree Medical Plan are:

Blue Cross Blue Shield of Texas	***EnvisionRx***
Claims Division P.O. Box 660044 Dallas, Texas 75266-0044 1-800-521-2227	Pharmacy Appeals 2181 E. Aurora Rd., Suite 201 Twinsburg, OH 44087 1- 800-595-8531

The Claims Administrators only provide administrative services to the Retiree Welfare Plan. The Claims Administrators do not insure or otherwise guarantee the medical and prescription drug benefits under the Retiree Welfare Plan.

Agent for Service of Legal Process

Legal Process for the Retiree Welfare Plan may be served on EPE.

Your ERISA Rights

As a participant in the Retiree Welfare Plan, you're entitled to certain rights and protections under ERISA. ERISA is a law that applies to certain kinds of employer-sponsored benefit plans.

ERISA Provides That You'll Be Entitled to ...	► Receive information about your Retiree Welfare Plan benefits. ► Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Retiree Welfare Plan, including insurance contracts and a copy of the

	plan's latest annual report (Form 5500 series) filed by the Retiree Welfare Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. ▶ Obtain copies of all documents governing the operation of the Retiree Welfare Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPDs upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. ▶ Receive a summary of the Retiree Welfare 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 healthcare coverage for yourself, Spouse, or Dependents if there is a loss of medical and prescription drug coverage under the Retiree Welfare Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD and the documents governing the Retiree Welfare Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Retiree Welfare Plan. The people who operate the Retiree Welfare Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

Here are some of ERISA's requirements:

No one, including EPE, may discriminate against you in any way to prevent you from obtaining a benefit as provided for in this plan or from exercising your rights under ERISA.

If your claim for benefits is denied 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, you can take steps to enforce your rights. For instance, if you request a copy of the plan documents or latest annual report from the Plan Administrator and don't 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 $149 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 has been denied improperly or ignored in whole or in part, you may file suit in a federal court.

If you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a Medical Child Support Order ("**QMCSO**"), you may file suit in federal court.

If plan fiduciaries misuse the plan's money or if you're 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're successful, the court may order the person you've sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — if, for example, it finds that your claim is frivolous.

If you have any questions about the Retiree Welfare Plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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.

NOTICES

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas ("**BCBSTX**") hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas ("**Host Blues**") may have contracts similar to the contracts described above with certain Providers ("**Host Blue Providers**") in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the **lower of**:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

SPECIAL REQUIREMENTS REGARDING MATERNITY AND NEWBORN CARE

The Pre-65 Retiree Medical Plan 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE
YOUR RIGHTS AFTER A MASTECTOMY

In the case of a Participant receiving benefits under the Pre-65 Retiree Medical Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Out-of-Pocket Maximum and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE
PAYMENT FOR SERVICES PERFORMED BY NON-NETWORK PROVIDERS

Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your Pre-65 Retiree Medical Plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners who are not members of that network. You may be responsible for payment of all or part of the fees for those professional services that are not paid or covered by the Pre-65 Retiree Medical Plan.

NOTICE OF PRIVACY PRACTICES FOR EL PASO ELECTRIC COMPANY EMPLOYEE WELFARE PLAN AND RETIREE WELFARE BENEFIT PLAN PARTICIPANTS AND THEIR COVERED SPOUSES AND DEPENDENTS

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

EFFECTIVE JUNE 2012

The privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**") protect the manner in which your protected health information ("**PHI**") may be used and disclosed by the El Paso Electric Company Employee Welfare Benefit Plan and the El Paso Electric Company Retiree Welfare Benefit Plan (collectively the "**Plan**"). The purpose of this notice is to provide you with information regarding your PHI privacy rights.

GENERAL RULES REGARDING HEALTH INFORMATION

Information about you and your health is personal. The Plan is committed to protecting health information about you (i.e., PHI) which is obtained in connection with the operation and administration of the Plan. This notice will tell you about the ways in which the Plan and its Business Associates (e.g. the third party administrators such as Blue Cross Blue Shield of Texas and EnvisionRX (referred to as the "**Business Associate**")) may use and disclose PHI about you. It also describes your rights regarding and certain obligations the Plan has regarding the use and disclosure of PHI.

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to your PHI;
- notify you following a breach of unsecured PHI; and
- follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that the Plan may use and disclose PHI. Except as described below, authorization or an opportunity to object is not required for these uses or disclosures. In most cases, the Plan tries not to use, disclose, or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request. For each category of uses or disclosures this notice will give some examples. Not every use or disclosure in a category will be listed. In addition, many of the uses and disclosures may be performed on the Plan's behalf by a Business Associate. However, all of the ways the Plan is permitted to use and disclose PHI will fall within one of the categories described below.

- **For Treatment.** The Plan may receive, use and disclose PHI about you to provide you with or help you to obtain health treatment or services. For example, the Business Associate may request and receive from your doctor information about the health condition for which you are seeking treatment in order to determine if the treatment you are seeking is covered by the Plan. The Plan may also contact you to provide information about treatment alternatives or other health-related benefits that may be of interest to you.

- **For Payment.** The Plan may receive, use and disclose PHI about you so that the bills for health treatment and services you have received may be paid by the Plan. For example, the Business Associate may need to have information about a surgery which you have received to determine payment for services. Similarly, the Plan may receive use and disclose PHI to the claims administrator to provide it with information necessary to process an appeal that you file.

- **For Health Care Operations.** The Plan may receive, use and disclose PHI about you for purposes of the Plan's operations such as underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance, for legal or auditing functions or for general management and administrative activities. For instance, the Business Associate or an outside auditing firm on behalf of the Plan may perform a claims audit. The Plan is prohibited from using or disclosing your genetic information for underwriting purposes.

- **Plan Sponsor Information Request.** The Plan may disclose to El Paso Electric Company (the "**Company**") summary health information (i.e., de-identified statistical information that summarizes the claims history, claims expenses or type of claims experienced by covered persons under the Plan) for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or determining Plan design.

  The Plan may also disclose to the Company information on whether a person is participating in the Plan and his or her benefit elections.

  Plan may also disclose PHI to the Company for specific plan administration purposes such as treatment, payment or health care operations, as described above.

  The Company can only be provided PHI regarding covered persons as provided in the Plan document and consistent with this notice.

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you advise the Plan otherwise by completing the attached Disclosure Objection Form and returning a copy of such completed form to the Plan's Contact Person, the Plan will be entitled to disclose PHI to a close family member or other person you identify that is directly relevant to such individual's involvement in your health care treatment or payment for your health care treatment as follows: (i) if you are married, to your spouse and (ii) if you are covered by the Plan as a child (regardless of whether you have attained age 18), to either of your parents (which may include a stepparent). The Plan will have the right to make such disclosures as long as you are covered by the Plan (including coverage following reenrollment should you discontinue coverage and reenroll in the Plan) or have claims pending under the Plan following your termination of coverage. However, if you are age 18 or older, you may file a Disclosure Objection Form at any time if you want the Plan to cease making family member disclosures as described above. Your Disclosure Objection Form should be returned to the Plan's Contact Person.

  In rare circumstances, the Plan may release a limited amount of PHI to aid your family members, close friends, or disaster relief personnel in locating you in an emergency or in case of your incapacity. Whenever possible, you will be given an opportunity to agree or object before the Plan makes such use or disclosure.

- **Pursuant to Your Authorization.** Other uses and disclosures of PHI not covered by this notice or the laws that apply to the Plan, such as uses and disclosures for

marketing or the sale of your PHI, will be made only with your written permission. If you sign an authorization giving the Plan permission to use or disclose PHI about you, you may revoke that authorization, in writing, at any time effective with respect to future uses and disclosures of your PHI.

SPECIAL SITUATIONS

The Plan will use or disclose PHI about you in the following special situations as follows:

- As required by federal, state or local law.
- To avert a serious threat to the health or safety of you, someone else or the public.
- If you are a member of the military or a veteran, to military command authorities.
- In connection with national security or intelligence activities or protective services for government officials.
- For workers' compensation or similar programs.
- To respond to a court or administrative order, a subpoena, discovery request or other lawful process.
- As requested by federal, state and local law enforcement officials or a correctional institution.
- For public health activities, such as disease control, child abuse or neglect or the Federal Food and Drug Administration with respect to adverse events or product defects.
- To government authorities for victims of abuse, neglect or domestic violence.
- With respect to a decedent, to a coroner or medical examiner.
- To organ procurement organizations to facilitate organ, eye or tissue donations or transplants.
- To facilitate medical research, subject to special rules and restrictions under HIPAA.
- For activities authorized by law for oversight of the health care system or government benefit programs.
- To the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rules.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding PHI the Plan has about you:

- **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of PHI that the Plan or the Business Associates have about you.[1] Usually, this includes health and billing records. You must submit your request in writing to the Plan's Contact Person or the Business Associate. The Plan may charge a fee for producing and mailing the copies and, in certain limited circumstances, may deny your request. To the extent that the Plan maintains your PHI electronically, you may elect to receive a copy of such information in an electronic format, and if you

[1] If you are a participant in a fully insured health maintenance organization ("**HMO**") or other insured health benefit, you need to contact the HMO or insurer. This applies to all of the individual rights described in this notice.

choose to have the copy directly transmitted to a person you designate. The Plan may charge a fee for the labor costs of responding to your request.

- **Right to Amend.** If you feel that PHI the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. Your request must be made in writing and submitted to the Plan's Contact Person or Business Associate. If the Plan denies your request, you may file a written statement of disagreement.
- **Right to an Accounting of Disclosures.** You have the right to request an "**accounting of disclosures**." This is a list of the disclosures the Plan made of PHI about you for reasons other than treatment, payment or health care operations or pursuant to your authorization. Your request must be in writing to the Plan's Contact Person or Business Associate. If you request such an accounting more than once in a 12-month period, the Plan may charge a reasonable fee.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI the Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI the Plan discloses about you to someone who is involved in the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had. Generally, the Plan is not required to agree to your request for restrictions. To request restrictions, you must make your request in writing to the Plan's Contact Person or Business Associate.
- **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail. Your request must be made in writing to the Plan's Contact Person or Business Associate. The Plan will accommodate all reasonable requests.
- **Right to a Copy of This Notice.** You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice by logging onto the company intranet under the Human Resources – Benefits section.

WHO WILL FOLLOW THIS NOTICE

The privacy practices described in this notice will be followed by (i) the Plan with respect to its health care components (i.e., the medical, dental, vision, health care reimbursement account, and employee assistance program,)[2] and its fiduciaries (such as the Plan Administrator), (ii) the Plan's Business Associates and (iii) to the extent they are involved in the operation and administration of the health care components of the Plan, by the Company and its employees.

The non-health care components of the Plan (i.e., life insurance, disability, accidental death and dismemberment and the dependent care assistance program) are not subject to the HIPAA privacy rules and the terms of this notice.

CHANGES TO THIS NOTICE

The Plan reserves the right to change this notice, effective for PHI the Plan already has about you as well as any information it receives in the future.

[2] This notice covers the self-insured health care components under the Plan. If you are a participant in a fully insured HMO or other insured health benefit component, you should receive a separate privacy notice directly from the HMO.

PLAN CONTACTS

If you have questions regarding this notice or your privacy rights, you may contact the Plan's Contact Person or Privacy Officer. The Plan's Contact Person is Benefits Manager (915) 543-5985. The Plan's Privacy Officer is William Stiller (915) 521-4452.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan's Contact Person or Privacy Officer. All complaints must be submitted in writing. A copy of such procedures can be obtained from the Plan's Contact Person without charge upon written request. You also may file a complaint with the Secretary of the Department of Health and Human Services. If you believe that your privacy rights have been violated. You will not be penalized for filing a complaint.

HEALTH PROVIDERS AND YOUR HEALTH INFORMATION

Health providers (such as doctors, medical clinics, health maintenance organizations, insurers, hospitals, etc.) may also use and disclose PHI about you. You also have rights regarding the PHI which they obtain and have about you. You should consult the notices of privacy practices which you receive from health care providers for information regarding how and under what circumstances they may use and release your PHI and what rights you have with respect to their practices regarding your PHI.

[Attachment Objection to Notification Disclosure Form]