NOTICE OF TEN DAY RIGHT TO EXAMINE CONTRACT

Within ten days after its delivery to the holder, this contract may be surrendered by delivering or mailing it to the Company's Home Office, branch office, or agent through whom it was purchased. Upon such surrender, any premiums paid will be returned.

GROUP HOSPITAL *Service*, INC.

GROUP HOSPITAL SERVICE, INCORPORATED

Dallas, Texas

(herein called the Plan)

has, in consideration of the application herefor and the payment in advance of the initial membership charges, issued this Agreement to the Member named below. The Agreement is not cancellable by the Plan, but is subject to benefit and rate adjustments as provided for in Article IX, Section B. While this Agreement is in force all participants hereunder shall be entitled to the benefits hereof, under the definitions and subject to the terms and conditions of the Articles on the following pages.

The duration of this membership is subject to the provisions of Article X.

, Member. Certificate No.

Group No.	Coverage effective Mo. Day Year	Room Allowance	Basic Coverage Deductible	Major Medical Corridor Deductible

Paul L. Beaudry Jr.
President

8345-M368

IMPORTANT NOTICE

To obtain information or make a complaint:

- You may call Blue Cross and Blue Shield of Texas toll-free telephone number for information or to make a complaint at:

  1-888-697-0683

- You may also write to Blue Cross and Blue Shield of Texas at:

  P. O. Box 3236
  Naperville, Illinois 60566-7236

- You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

  1-800-252-3439

- You may write the Texas Department of Insurance at:

  P. O. Box 149104
  Austin, Texas 78714-9104
  Fax: (512) 475-1771
  Web: http://www.tdi.texas.gov
  E-mail: ConsumerProtection@tdi.texas.gov

- **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

- **ATTACH THIS NOTICE TO YOUR POLICY:** This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

- Usted puede llamar al numero de telefono gratis de Blue Cross and Blue Shield of Texas para informacion o para someter una queja al:

  1-888-697-0683

- Usted tambien puede escribir a Blue Cross and Blue Shield of Texas al:

  P. O. Box 3236
  Naperville, Illinois 60566-7236

- Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al :

  1-800-252-3439

- Puede escribir al Departmento de Seguros de Texas:

  P. O. Box 149104
  Austin, Texas 78714-9104
  Fax: (512) 475-1771
  Web: http://www.tdi.texas.gov
  E-mail: ConsumerProtection@tdi.texas.gov

- **DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

- **UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

BLUE CROSS MEMBERSHIP AGREEMENT—DEDUCTIBLE THREE HUNDRED SERVICE

ARTICLE I — DEFINITIONS

AS USED HEREIN:

A. MEMBER shall mean the person named on the face of this Agreement.

B. DEPENDENT shall mean only the Member's spouse and any unmarried child under nineteen years of age for whose coverage application has been made by the Member and accepted by the Plan.

C. SPONSORED DEPENDENT shall mean any unmarried child of the Member between the ages of nineteen and twenty-four years, inclusive, for whose coverage application has been made by the Member and accepted by the Plan.

D. PARTICIPANT shall mean the Member, a dependent, or a sponsored dependent, as above defined.

E. MEMBER HOSPITAL shall mean any hospital with which the Plan has entered into a written contract for the rendition of hospital services which are provided by this Agreement.

F. NON-MEMBER HOSPITAL shall mean any hospital other than a member hospital, provided, however, that except in case of accident, such non-member hospital must be registered with the American Hospital Association and approved by the Plan for the rendition of care on a non-member hospital basis. The term does not include health resorts, nursing homes, rest homes, or any institutions primarily providing convalescent or custodial care.

G. PHYSICIAN shall mean a person (other than a hospital resident or interne) who is a Doctor of Medicine, Doctor of Osteopathy, or Doctor of Podiatry and who is a member of his county medical society, state osteopathic association or state podiatry association or eligible for membership in such society or association; the term shall not be deemed to include a Doctor of Dentistry, a Doctor of Optometry, or a Doctor of Chiropractic, nor a Doctor of Medicine, Osteopathy or Podiatry ineligible for membership in his respective society or association. The terms Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, and Doctor of Chiropractic as used herein, shall have the meaning assigned to them by Article 3.70-2, Subsection B of the Insurance Code of Texas.

H. PERIOD OF HOSPITAL CONFINEMENT shall mean a continuous period of hospital confinement, but successive periods shall be considered to be continuous unless the last date of discharge and the date of re-admission are separated by at least ninety days.

I. HOSPITAL CARE shall mean the services for which benefits are provided under this Agreement. Such care is subject to the rules and regulations of the hospital selected by the participant, and limited to cases of illness and injury acceptable to such hospital. The term does not include room accomodations, meals, or any other services rendered to ambulatory patients on a self-care basis, or an arrangement contemplating provision of only minimal services with meals to be taken outside the hospital bedroom.

ARTICLE II — DURATION OF HOSPITAL CARE

A. Except as otherwise specified herein, for each period of hospital confinement beginning after the effective date of the patient's coverage hereunder, each participant shall be entitled to a maximum of 120 days of in-patient hospital care benefits. Care received in a non-member hospital shall apply against the available number of days, just as in a member hospital.

B. Hospital care in any hospital will end at the time the participant is discharged as a bed patient by the attending physician.

ARTICLE III — ELIGIBILITY FOR MATERNITY CARE

A. Benefits for conditions arising from pregnancy (including any complications of pregnancy) shall be available only after this coverage has been effective, including both the obstetrical patient and her husband, one as Member and the other as dependent, for at least nine consecutive months immediately preceding the termination of the pregnancy.

B. If coverage hereunder was obtained by conversion from group coverage or by transfer from a different form of coverage issued by the Plan, credit will be allowed for the previous consecutive period of coverage of both the obstetrical patient and her husband under a single certificate in satisfaction of the nine months maternity waiting period provided in Section A of this Article III.

C. No benefits shall be available for any hospital admission occurring after termination of this Agreement or the patient's coverage as a participant hereunder.

ARTICLE IV — DEDUCTIBLE CLAUSE

A. Each member hospital admission shall be subject to a deduction in benefits in the amount shown under "Basic Coverage Deductible" in the schedule appearing on the face of this Agreement. The deductible does not apply to out-patient care, nor to Texas non-member hospital admissions. In obstetrical cases, if the patient is admitted more than once for one pregnancy, the deductible will be applied only once for all such admissions.

ARTICLE V — HOSPITAL CARE IN MEMBER HOSPITALS

A. **BED-PATIENT CARE:** Subject to all other provisions of this Agreement, any participant, when admitted to a member hospital as a bed patient, shall be entitled (subject to the deductible, when applicable) to such of the following items of service as are furnished by the hospital and used by the patient while confined therein, under orders of the attending physician, if and to the extent necessary for treatment of the condition for which the patient is confined:

1. Room accommodations, including meals, special diets and general nursing service: a daily allowance of up to the

amount shown under "Room Allowance" in the schedule appearing on the face of this Agreement.

2. All other usual hospital services necessary to the treatment of the patient, ordered by the attending physician, for use while in the hospital — except blood and plasma, but including transfusion services and blood typing and cross-matching of patient and donor.

B. **OUT-PATIENT BENEFITS:** Subject to all other provisions of this Agreement, all usual hospital services, except blood and plasma, will be provided for minor surgery, on the day of such surgery, and for emergency care rendered within twenty-four hours after an accident. The deductible does not apply.

ARTICLE VI — HOSPITAL CARE IN NON-MEMBER HOSPITALS

A. **BED-PATIENT CARE:** Subject to all other provisions of this Agreement, any participant receiving bed-patient care in a non-member hospital shall be provided indemnity benefits as follows (the deductible does not apply):

1. Hospital located in Texas: The Plan will pay an allowance equivalent to 75% of the benefits which would have been provided if the same care had been furnished by a member hospital.
2. Hospital not located in Texas: The Plan will pay an allowance equivalent to the benefits which would have been provided if the same care had been furnished by a member hospital.

B. **OUT-PATIENT BENEFITS:** Subject to all other provisions of this Agreement, all usual hospital services, except blood and plasma, will be provided for minor surgery, on the day of such surgery, and for emergency care rendered within twenty-four hours after an accident. The deductible does not apply.

ARTICLE VII — LIMITATIONS AND EXCLUSIONS

The benefits of this Agreement are not available for:

A. Any care rendered during the first year following the effective date of the patient's coverage hereunder, for abnormal physical or mental conditions, whether active or inactive, existing before the patient became a participant hereunder, including all deformities, ailments or prior injuries which may thereafter become aggravated by subsequent injury or disease. If coverage hereunder was obtained by conversion from group coverage or by transfer from a different form of coverage issued by the Plan, credit will be allowed for the previous consecutive period of coverage in determiniting whether the foregoing provisions of this Section A are applicable.

B. Hospital admission primarily for diagnostic or evaluation procedures.

C. Care or services received or rendered through or in Veterans Administration facilities; any care for which benefits are, or could upon proper claim be provided under the Workmen's Compensation law, or any other 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.

D. Any care, to the extent that such benefits would duplicate benefits available to the participant under any other coverage issued by the Plan or by any other Blue Cross Plan.

E. Care in a health resort, rest home, nursing home, or any institution primarily providing convalescent or custodial care.

F. Blood and plasma.

G. Care rendered to any dependent child or sponsored dependent after marriage.

H. Services for out-patient care, except for minor surgery and in accident cases as herein provided.

I. Ambulance services.

J. Any care or services provided during the course of a hospital stay commencing before or after the period of time during which the patient is covered as a participant hereunder.

K. Obstetrical care, unless both the patient and her husband have held coverage hereunder as specified in Article III.

L. Services provided to ambulatory patients on a self-care basis as described in Section I of Article I of this Agreement.

M. Any service or supplies not specified herein as benefits.

ARTICLE VIII — STANDARD PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This Agreement includes the application, a copy of which is attached, and the endorsements hereon, if any, and constitutes the entire contract. No agent has authority to change this Agreement or to waive any of its provisions. No change in this Agreement shall be valid unless approved by an executive officer of the Plan and such approval be endorsed hereon.

B. TIME LIMIT ON CERTAIN DEFENSES: (a) After one year from the effective date of this Agreement no misstatements, except fraudulent misstatements, made in the application shall be used to void the Agreement or to deny a claim for hospital care commencing after the expiration of such one-year period. (b) No claim for hospitalization occurring after one year following the effective date of this Agreement shall be reduced or denied on the ground that the condition requiring hospitalization had existed prior to the effective date, unless such condition was excluded from coverage by name or specific description on the date of the hospital admission.

C. GRACE PERIOD: A grace period of ten days shall be allowed from the due date of each payment, or thirty-one days if on a quarterly, semi-annual or annual payment basis, during which grace period this Agreement will continue in force, subject to the right of the Plan to terminate the coverage in accordance with the provisions hereof.

D. REINSTATEMENT: If default be made in the stipulated payments for this Agreement, the subsequent acceptance of such payment by the Plan or any of its duly authorized agents shall reinstate the Agreement, but only to include benefits for illness or injury originating thereafter. In all other respects, the Member and the Plan shall have the same rights hereunder as they had under the Agreement immediately before the due date of the defaulted membership charges, including the right of the Member to apply the period of time this Agreement was in effect immediately before the due date of the defaulted premium toward satisfaction of any waiting periods for benefits, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any payments accepted in connection with a reinstatement shall be applied to a period for which membership charges have not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

E. NOTICE OF CLAIM: The Member must notify any member hospital of this membership at the time of admission unless prevented by uncontrollable circumstances, and then as soon thereafter as possible. The Member shall give or cause to be given written notice to the Plan or its duly authorized agent, on forms furnished by it, within thirty days or as soon as reasonably possible after any participant receives in a non-member hospital any of the services provided herein.

F. CLAIM FORMS: Notice given as provided above shall be deemed to be notice to the Plan, and no further claim forms shall be required of the Member unless specifically requested by the Plan.

G. PROOFS OF LOSS: Any obligation for non-member hospital services must be reported to the home office of the Plan at Dallas, Texas, by the Member within ninety days after discharge. Failure to give notice or furnish proof within the time specified shall not invalidate any rights if it shall be shown not to have been reasonably possible to give such notice or furnish such proof, and that it was done as soon as was reasonably possible.

H. TIME OF PAYMENT OF CLAIMS: Benefits payable under this Agreement for any loss will be paid immediately upon receipt of due written proof of such loss.

I. PAYMENT OF CLAIMS: Any benefits hereunder, payable to the Member, shall, if unpaid at the Member's death, be paid to his or her surviving spouse, if named as a dependent hereunder, as beneficiary; if there is no surviving dependent spouse, then such benefits shall be paid to the Member's estate. Any other accrued indemnities unpaid at the Member's death may, at the option of the Plan, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Member.

J. PHYSICAL EXAMINATIONS AND AUTOPSY: The Plan, at its own expense, shall have the right and opportunity to examine the person of a claimant hereunder when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death where it is not forbidden by law.

K. LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Agreement unless brought within three years after the date that the patient was admitted to a hospital.

ARTICLE IX — GENERAL PROVISIONS

A. The membership charges and manner of payment thereof shall be as set out in the application herefor.

B. The Plan reserves the right to change the benefits or the charges therefor on sixty days notice to the Member and such change shall become effective on the date specified in said notice.

C. The Plan shall not be liable for any act or omission by any hospital, physician, their agents or employees, in caring for a person receiving services under this Agreement, and no responsibility attaches hereunder for inability of any hospital to furnish accommodations or services.

D. The Member, on behalf of himself and all other participants, agrees that the attending physician, nurse, or any hospital is authorized to furnish the Plan all information and records or copies of records relating to the diagnosis, treatment, or care of the patient; and such participants shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the aforesaid from disclosing such information and records.

E. Benefits available hereunder are not assignable.

ARTICLE X — TERMINATION OF COVERAGE

A. This Agreement will automatically terminate:

1. At the expiration of the last period for which the membership charges shall have been paid to the Plan, subject to the grace period for payment of renewal charges.

2. As to any dependent child of the Member, when such child becomes 19 years of age (subject to right of continuation as a sponsored dependent on payment of the applicable membership charges), or marries prior thereto; or, as to any sponsored dependent, when he or she becomes 25 years of age, or marries prior thereto; but in any such event coverage hereunder shall continue for the remainder of the period for which membership charges have been accepted by the Plan.

NOTICE OF TEN DAY RIGHT TO EXAMINE CONTRACT

Within ten days after its delivery to the holder, this contract may be surrendered by delivering or mailing it to the Company's Home Office, branch office, or agent through whom it was purchased. Upon such surrender, any premiums paid will be returned.

GLH

Group Life and Health Insurance Company

GROUP LIFE AND HEALTH INSURANCE COMPANY

Dallas, Texas

(herein called the Insurer)

has, in consideration of the application herefor and the payment in advance of the initial premium, issued this Medical-Surgical Insurance Policy to the person named below. The Policy is not cancellable by the Insurer, but is subject to benefit and rate adjustments as provided for in Article VII, Section B. While this Policy is in force all participants hereunder shall be entitled to the benefits hereof, under the definitions and subject to the terms and conditions of the Articles on the following pages.

The duration of this Policy is subject to the provisions of Article VIII.

, Policyholder. Certificate No.

Group No.	Coverage effective Mo. Day Year	

President

MEDICAL-SURGICAL INSURANCE POLICY—THREE HUNDRED SERVICE

ARTICLE I — DEFINITIONS

AS USED HEREIN:

A. POLICYHOLDER shall mean the person named on the face of this Policy.

B. DEPENDENT shall mean only the Policyholder's spouse and any unmarried child under nineteen years of age for whose coverage application has been made by the Policyholder and accepted by the Insurer.

C. SPONSORED DEPENDENT shall mean any unmarried child of the Policyholder between the ages of nineteen and twenty-four years, inclusive, for whose coverage application has been made by the Policyholder and accepted by the Insurer.

D. PARTICIPANT shall mean the Policyholder, a dependent, or a sponsored dependent, as above defined.

E. HOSPITAL shall mean any hospital (except Veterans Administration facilities) registered with the American Hospital Association. It does not include health resorts, nursing homes, rest homes, or any institutions primarily providing convalescent or custodial care.

F. PHYSICIAN shall mean a person (other than a hospital resident or interne) who is a Doctor of Medicine, Doctor of Osteopathy, or Doctor of Podiatry and who is a member of his county medical society, state osteopathic association or state podiatry association or eligible for membership in such society or association; the term shall not be deemed to include a Doctor if Dentistry, a Doctor of Optometry, or a Doctor of Chiropractic, nor a Doctor of Medicine, Osteopathy or Podiatry ineligible for membership in his respective society or association. The terms Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, and Doctor of Chiropractic as used herein, shall have the meaning assigned to them by Article 3.70-2, Subsection B of the Insurance Code of Texas.

G. POLICY YEAR shall mean each succeeding twelve-month period, beginning on the effective date of this Policy.

H. BENEFITS shall mean payment on charges for services of a physician to any participant. Such service (except as otherwise specified in the several Sections of Article IV, below) may be performed in or out of a hospital.

ARTICLE II — BENEFITS AND PAYMENTS

A. Subject to the qualifications, limitations and exclusions set forth herein, the Insurer will pay to the physician of the Policyholder's choice the amount of his charges for services listed in the Schedule of Benefits (Article IV), provided, however, that:
   1. Such payment shall not exceed the amount specified in Article IV, and
   2. Such services must be performed by a physician as defined herein.

B. If two or more surgical procedures are performed at the same time or during the same hospital stay, in the same operative area, the amount paid will be on the major procedure with no allowance for other procedures. When two or more procedures in different operative areas are performed at the same time or during the same hospital stay, the highest allowance will be paid, plus 50 percent of the allowance for the next highest procedure, with no allowance for other procedures; the total amount allowed will not exceed $300.00 for all surgical services.

C. All payments for operations or services as set forth in Article IV are payable to the physician of the Policyholder's choice rendering the service, except that such payments will be made to the Policyholder if he so directs before payment is made to the physician. Such payment in either event shall constitute full discharge of all responsibility of the Insurer to the Policyholder for benefits on account of such services.

D. It is understood and agreed that the schedule of benefit payments is not intended to and does not fix the value of the services of the attending physician nor in any way relate to or regulate such value; that the attending physician is privileged to make his regular charges and that the stipulated amounts are merely to apply as credits thereon. Payment for surgical and radiation procedures not listed in Article IV will be made on a proportionate basis, as determined by the Insurer.

ARTICLE III — ELIGIBILITY FOR MATERNITY CARE

A. Benefits for conditions arising from pregnancy (including any complications of pregnancy) shall be available only after this coverage has been effective, including both the obstetrical patient and her husband, one as Policyholder and the other as dependent, for at least nine consecutive months immediately preceding the termination of the pregnancy.

B. If coverage hereunder was obtained by conversion from group coverage or by transfer from a different form of coverage issued by the Insurer, credit will be allowed for the previous consecutive period of coverage of both the obstetrical patient and her husband under a single certificate in satisfaction of the nine months maternity waiting period provided in Section A of this Article III.

C. No benefits shall be available for any services rendered after termination of this Policy or of the patient's coverage as a participant hereunder.

ARTICLE IV — SCHEDULE OF BENEFITS

All benefits detailed in this Article are in the nature of indemnity against the fees charged by physicians for their services rendered to the patient under direct employment, and not for any services rendered by physicians under employment by a hospital. Each specified allowance is to be considered a maximum amount, and the benefit shall not exceed the fee actually charged.

A. **MEDICAL BENEFITS:** When a participant is confined to a hospital as a medical patient, payment will be made on the attending physician's charges as follows:
   1. $6.00 per day for the first five days; $5.00 per day for the next five days; $4.00 per day thereafter. The maximum payment for medical benefits shall not exceed $300.00 per policy year.
   2. No medical benefits will be provided for any condition for which payments are available for surgical benefits, obstetrical benefits, or radiation or X-ray benefits, unless the medical hospital admission occurs at least sixty days following discharge from a hospital for surgical or obstetrical care, or the date such professional services were rendered outside a hospital; or, if treatment by radiation or X-ray was employed, at least sixty days after the conclusion of such course of treatment.
   3. No medical benefits will be provided for any child under the age of 45 days.

B. **SURGICAL BENEFITS** (Including Obstetrical):

ABDOMEN	Allowance
Appendectomy	$150.00
Gastrectomy, sub-total	215.00
Removal of Gallbladder	175.00
Colectomy	215.00
Exploratory Laparotomy	125.00

AMPUTATION OF	Allowance
Thigh	$165.00
Leg	130.00
Entire foot, arm, forearm or hand	100.00
Finger	50.00
Two or more	80.00
Toe	30.00
Two or more	40.00

BREAST	
Simple amputation	$100.00
Radical removal	215.00
Removal of cysts	50.00
Removal of benign tumors	50.00
Bilateral	80.00

CHEST	
Thoracoplasty	
First stage	$165.00
Second stage	100.00
Third stage	65.00
Total Lobectomy or pneumonectomy	300.00
Total pulmonary decortication	215.00
Exploratory thoracotomy	165.00

DISLOCATION	
Knee, closed reduction	$ 35.00
Open reduction	165.00
Hip, closed reduction	65.00
Open reduction	190.00
Clavicle, closed reduction	35.00
Open reduction	100.00
Elbow, closed reduction	30.00
Open reduction	130.00

EAR, NOSE AND THROAT	
Mastoidectomy, simple	$130.00
Radical	190.00
Tonsillectomy, with or without adenoidectomy, any age	40.00
Frontal sinusotomy, external	
Simple, unilateral	35.00
Radical, unilateral	130.00
Submucous resection	100.00
Excision of nasal polyp	7.50
Antrum puncture	7.50
Bronchoscopy	65.00
Tracheotomy	65.00

EYE	
Removal of cataract	$215.00
Needling of cataract	65.00
Cutting of extrinsic eye muscle	165.00
Bilateral	190.00
Removal of eyeball	130.00
Pterygium	65.00

FRACTURE, TREATMENT OF	
Hip (femur), closed reduction	$100.00
Open reduction	215.00
Upper arm, closed reduction	50.00
Open reduction	165.00
Forearm (radius or ulna)	
Closed reduction	50.00
Open reduction	130.00
Leg	
Tibia, closed reduction	50.00
Open reduction	165.00
Fibula, closed reduction	35.00
Open reduction	100.00
Tibia and fibula	
Closed reduction	$ 65.00
Open reduction	190.00
Finger, closed reduction	15.00
Open reduction	65.00
Toe, closed reduction	11.00
Open reduction	50.00

GENITO-URINARY TRACT	
Removal of kidney	$215.00
Excision of cyst of kidney	190.00
Removal of bladder, partial	165.00
Complete	300.00
Cystoscopy, diagnostic	15.00
With biopsy	35.00
With stone removal	100.00
Removal of tumor	100.00
With Ureteral Catheterization	35.00
Removal of prostate	215.00
Circumcision of newborn	10.00
Under age of ten years	15.00
Ten years of age or over	33.00
Excision of hydrocele	65.00
Excision of varicocele	65.00
Removal of testes	65.00
Radical, unilateral or bilateral with retroperitoneal gland dissection	300.00

GOITRE	
Thyroidectomy	
Total with neck dissection	$300.00
Total without neck dissection	190.00
Sub-total	165.00
Excision of adenoma of thyroid	130.00

HERNIA	
Inguinal, unilateral	$100.00
Bilateral	130.00

JOINTS	
Open operation, for repair or removal of foreign body	
Shoulder	$100.00
Elbow, wrist, ankle	100.00
Knee	130.00
Hip	165.00
Removal of bursa	50.00

LACERATIONS	
Suturing	$ 8.00
(Subject to higher allowance, based on extent of laceration and location)	

LIGAMENTS OR TENDONS	
Suturing of tendons	
Extensors	$ 35.00
Two or more	50.00
Flexors	65.00
Two or more	100.00
Tendon transplant	100.00
Flexorplasty of elbow	165.00

NERVOUS SYSTEM	
Removal of brain cyst, abscess or tumor	$300.00
Pneumo-encephalogram	65.00
Myelogram	33.00
Fractured skull, open reduction	215.00
Sympathectomy, cervical	165.00
Bilateral	215.00

OBSTETRICS AND GYNECOLOGY	Allowance
Normal delivery with prenatal and postnatal care	$ 75.00
Cesarean section	165.00
Extra-uterine pregnancy	145.00
Hysterectomy, total	165.00
D & C, for:	
Removal of polyps	33.00
Therapeutic abortion	50.00
Repair of rectocele	80.00
Repair of rectocele and cystocele	145.00
PARACENTESIS — TAPPING OF:	
Abdomen, chest, spine	$ 10.00
For each subsequent paracentesis	6.50
Maximum per policy year	40.00
Hydrocele	10.00
Joint	10.00
RECTUM	
Abdomino-perineal resection	$300.00
Cutting operation for radical cure of internal hemorrhoids	75.00
Cutting operation for fissure	50.00
Combination of above two procedures	100.00
Fistula in ano, simple	80.00
Sigmoidoscopy	10.00
TUMORS	
Excision of benign skin tumors, up to two	$ 15.00
Maximum multiple	40.00
VARICOSE VEINS	
Ligation, division and stripping of saphenous veins, bilateral	$ 80.00
Ligation of minor varicose vein	
Initial	15.00
Subsequent	10.00

C. **OBSTETRICAL BENEFITS:** Subject to the provisions of Article III, benefits for conditions arising from pregnancy (including any complications of pregnancy) shall be available as scheduled in Sections B and D of this Article IV; Sections A, E and F are not applicable to obstetrical cases.

D. **ANESTHESIA BENEFITS:** When rendered by an anesthetist other than the operating surgeon, payment for anesthesia services will be made on the following basis:

$5.00 plus up to 15 percent of the applicable surgical benefit.

E. **RADIATION THERAPY BENEFITS:** Payments for radium, radio-active isotopes, and x-ray treatments will be made on the basis of the following schedule. In no event will the maximum payment exceed $300.00 per policy year.

MALIGNANCIES	PER TREATMENT	MAXIMUM
Brain	$6.25	$125.00
Larynx	6.25	175.00
Stomach	6.25	125.00
Kidney	6.25	125.00
Ovaries	6.25	150.00
Testicle	6.25	200.00

NON-MALIGNANT DISEASES	PER TREATMENT	MAXIMUM
Bursitis	$4.00	$ 35.00
Carbuncle	4.00	25.00
Endometriosis	4.00	60.00

RADIO-ACTIVE ISOTOPES	$125.00

F. **SPECIAL PROFESSIONAL SERVICES:** When necessary for the proper health care of the patient, payment will be made for one-half the customary and reasonable charges for the following services, wherever rendered, and up to the following maximum payments per policy year.

Laboratory Examinations	up to $50.00
Diagnostic X-ray	up to $50.00
Physical Therapy	up to $25.00

These benefits are not available when the services are rendered in connection with a routine physical examination, or obstetrical care.

ARTICLE V — LIMITATIONS AND EXCLUSIONS

The benefits of this Policy are not available for:

A. Any care rendered during the first year following the effective date of the patient's coverage hereunder, for abnormal physical or mental conditions, whether active or inactive, existing before the patient became a participant hereunder, including all deformities, ailments or prior injuries which may thereafter become aggravated by subsequent injury or disease. If coverage hereunder was obtained by conversion from group coverage or by transfer from a different form of coverage issued by the Insurer, credit will be allowed for the previous consecutive period of coverage in determining whether the foregoing provisions of this Section A are applicable.

B. Any services rendered in connection with a routine physical examination, or any diagnostic or evaluation procedures not necessary to the proper treatment of an abnormal physical or mental condition.

C. Care or services received or rendered through or in Veterans Administration facilities; any care for which benefits are, or could upon proper claim be provided under the Workmen's Compensation law, or any other 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.

D. Dental care and treatment, except such surgery as may become necessary as a result of accidental bodily injury.

E. Blood, plasma, or transfusion services.

F. Anesthesia services rendered by the operating surgeon.

G. Care rendered to any dependent child or sponsored dependent, after marriage.

H. Any care or services provided during the course of a hospital stay commencing before or after the period of time during which the patient is covered as a participant hereunder.

I. Medical benefits for children under the age of 45 days.

J. Obstetrical care, unless both the patient and her husband have held coverage hereunder as specified in Article III.

K. Any care for which benefits are available to the patient under hospitalization coverage issued by any non-profit hospital service plan.

L. Any services or supplies not specifically listed as benefits.

M. Any services of a Doctor of Chiropractic, Doctor of Dentistry or Doctor of Optometry.

ARTICLE VI — STANDARD PROVISIONS

A. ENTIRE CONTRACT; CHANGES: This Policy includes the application, a copy of which is attached, and the endorsements hereon, if any, and constitutes the entire contract. No agent has authority to change this Policy or to waive any of its provisions. No change in this Policy shall be valid unless approved by an executive officer of the Insurer and such approval be endorsed hereon.

B. TIME LIMIT ON CERTAIN DEFENSES: (a) After one year from the effective date of this Policy no misstatements, except fraudulent misstatements, made in the application shall be used to void the Policy or to deny a claim for services rendered after the expiration of such one-year period. (b) No claim for services rendered after one year following the effective date of this Policy shall be reduced or denied on the ground that the condition requiring treatment had existed prior to the effective date, unless such condition was excluded from coverage by name or specific description on the date such services were rendered.

C. GRACE PERIOD: A grace period of ten days shall be allowed from the due date of each payment, or thirty-one days if on a quarterly, semi-annual or annual payment basis, during which grace period this Policy will continue in force, subject to the right of the Insurer to terminate the coverage in accordance with the provisions hereof.

D. REINSTATEMENT: If default be made in the stipulated payments for this Policy, the subsequent acceptance of such payment by the Insurer or any of its duly authorized agents shall reinstate the Policy, but only to include benefits for illness or injury originating thereafter. In all other respects, the Policyholder and the Insurer shall have the same rights hereunder as they had under the Policy immediately before the due date of the defaulted premium, including the right of the Policyholder to apply the period of time this Policy was in effect immediately before the due date of the defaulted premium toward satisfaction of any waiting periods for benefits, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any payments accepted in connection with a reinstatement shall be applied to a period for which premiums have not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

E. NOTICE OF CLAIM: The Policyholder shall give or cause to be given written notice to the Insurer or its duly authorized agent within thirty days or as soon thereafter as is reasonably possible after any participant receives any services for which a benefit is provided herein.

F. CLAIM FORMS: The Insurer, upon receipt of a notice of claim, will furnish to the Policyholder or to the patient's physician such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen days after the giving of such notice, the Policyholder shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed herein for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

G. PROOFS OF LOSS: Written proof of loss must be furnished to the home office of the Insurer at Dallas, Texas, by the Policyholder within ninety days after any participant receives services for which benefits are provided herein. Failure to give notice or furnish proof within the time specified shall not invalidate any rights if it shall be shown not to have been reasonably possible to give such notice or furnish such proof and that it was done as soon as was reasonably possible.

H. TIME OF PAYMENT OF CLAIMS: Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written proof of such loss.

I. PAYMENT OF CLAIMS: Any benefits hereunder, payable to the Policyholder, shall, if unpaid at the Policyholder's death, be paid to his or her surviving spouse, if named as a dependent hereunder, as beneficiary; if there is no surviving dependent spouse, then such benefits shall be paid to the Policyholder's estate. Any other accrued indemnities unpaid at the Policyholder's death may, at the option of the Insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Policyholder.

J. PHYSICIAL EXAMINATIONS AND AUTOPSY: The Insurer, at its own expense, shall have the right and opportunity to examine the person of a claimant hereunder, when and as often as it may reasonably require during the pendency of the claim, and to make an autopsy in case of death where it is not forbidden by law.

K. LEGAL ACTIONS: No action at law or in equity shall be brought to recover on this Policy unless brought within three years and ninety days after the date of rendition of the services for which claim is made.

ARTICLE VII — GENERAL PROVISIONS

A. The premiums and manner of payment thereof shall be as set out in the application herefor.

B. The Insurer reserves the right to change the benefits or the premiums on sixty days notice to the Policyholder, and such change shall become effective on the date specified in said notice.

C. The Insurer shall not be liable for any act or omission by any hospital, physician, their agents or employees, in caring for a person receiving services for which benefits are available under this Policy.

D. The Policyholder, on behalf of himself and all other participants, agrees that the attending physician, nurse, or any hospital is authorized to furnish the Insurer all information and records or copies of records relating to the diagnosis, treatment, or care of the patient; and such participants shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the aforesaid from disclosing such information and records.

E. Benefits available hereunder are not assignable.

ARTICLE VIII — TERMINATION OF COVERAGE

A. This Policy will automatically terminate:

1. At the expiration of the last period for which the premiums shall have been paid to the Insurer, subject to the grace period for payment of renewal premiums.

2. As to any dependent child of the Policyholder, when such child becomes 19 years of age (subject to right of continuation as a sponsored dependent on payment of the applicable premiums), or marries prior thereto; or, as to any sponsored dependent, when he or she becomes 25 years of age, or marries prior thereto; but in any such event coverage hereunder shall continue for the remainder of the period for which premiums have been accepted by the Insurer.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

BENEFIT BOOKLET AMENDMENT
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on January 1, 2022.

The terms of this Amendment supersede the terms of the Individual Insurance Contract to which this Amendment is attached and becomes a part of the Contract. Unless otherwise required by Federal or Texas law, in the event of a conflict between the terms of this Amendment and the terms of the Contract, the terms of this Amendment apply.

The Contract is hereby amended as indicated below:

The revisions to your Contract made by this Amendment are based upon new federal requirements contained in the Consolidated Appropriations Act, 2021. This includes requirements outlined in the No Surprises Act, a federal law enacted in 2020. These new requirements may impact your benefits.

Continuity of Care

If you are receiving covered services from a Participating Provider or Participating Facility who stops participating in the plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may elect to continue coverage for covered services from that provider or facility at the in-network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the provider (including receipt of postoperative care from such provider or facility with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than ninety (90) days beyond the date the plan notifies you of the provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Contract.

Federal No Surprises Act Definitions

The definitions below apply only to this Amendment. To the extent the same terms are defined in both the Contract and this Amendment, those terms will apply only to their use in the Contract or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

1. a medical screening examination performed in the emergency department of a hospital or an independent freestanding emergency department;
2. further medical examination or treatment you receive at a hospital, regardless of the department of the hospital, or an independent freestanding emergency department to evaluate and treat an Emergency Medical Condition until your condition is stabilized; and
3. covered services you receive from a Non-Participating Provider or Non-Participating Emergency Facility during the same visit after your Emergency Medical Condition has stabilized, and as part of outpatient observation or an inpatient or outpatient stay with respect to the same visit, unless:
    a. your Non-Participating Provider or Non-Participating Emergency Facility determines you can travel by non-medical or non-emergency transport;
    b. your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
    c. you have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSTX for furnishing such item or service under the Contract to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSTX for furnishing such item or service under the Contract to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a covered service, a physician or other health care provider who has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Contract to which this Amendment is attached, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to a covered service, a hospital or ambulatory surgical center that has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Contract to which this Amendment is attached, regardless of whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject plan.

Protections from Unexpected Costs for Medical Services from Non-Participating Providers

Your Contract contains provisions related to protection from surprise balance billing under Texas law. The federal laws provide additional financial protections for you when you receive some types of care from providers who do not participate in your network. If you receive the types of care listed below, your in-network cost-sharing levels will apply to any in-network deductible, out-of-pocket maximums/coinsurance, and stop-loss amounts. Additionally, for services below that are governed by federal law (instead of state law), your cost-sharing amount may be calculated on an amount that generally represents the median payment rate that BCBSTX has negotiated with Participating Providers for similar services in the area.

- Emergency Services from a Non-Participating Provider or Non-Participating Emergency Facility
- Covered non-emergency services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up your balance billing protections)
- Air Ambulance Services from Non-Participating Providers if the services would be covered if received from a Participating Provider.

Non-Participating Providers may not bill you for more than your deductible, coinsurance amounts, or copayment amounts for these types of services. There are limited instances when a Non-Participating Provider of the care listed above may send you a bill for up to the amount of that Non-Participating Provider's billed charges. You are only responsible for payment of the Non-Participating Provider's billed charges if, in advance of receiving services, you signed a written notice form that complies with applicable state and/or federal law.

The requirements of federal law that impact your costs for care from Non-Participating Providers may not apply in all cases. Sometimes, Texas law provisions relating to balance billing prohibitions may apply. **You may contact BCBSTX at the number of the back of your identification card with questions about claims or bills you have received from Non-Participating Providers.**

To the extent state and federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

NOTICE

This health insurance issuer believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at P.O. Box 660819, Dallas, Texas 75266-0819. You may also contact the U.S. Department of Health and Human Services at www.hhs.gov.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: James Springfield President

An Amendment

January 1, 2012

To be attached to and made a part of your Blue Cross and Blue Shield of Texas* Individual Plan Insurance Contract.

AMENDMENT TO THE CONTRACT

The General Provisions section of your Contract is modified to add the following new section:

Premium Rebates and Premium Abatements:

a. Rebate. In the event federal or state law requires Blue Cross and Blue Shield of Texas (BCBSTX) to rebate a portion of annual premiums paid, BCBSTX will directly provide any rebate owed Participants or former Participants to such persons in amounts as required by law.

If any rebate is owed a Participant or former Participant, BCBSTX will provide the rebate to the Participant or former Participant no later than August 1 following the end of the medical loss ratio ("MLR") reporting year.

BCBSTX will provide any rebate owed to a Participant in the form of a premium credit, lump-sum check or, if a Participant paid the premium using a credit card or direct debit, by lump-sum reimbursement to the account used to pay the premium. However, BCBSTX will provide any rebate owed to a former Participant in the form of lump-sum check or lump-sum reimbursement using the same method used for payment, such as credit card or direct debit.

If a rebate is provided in the form of a premium credit, BCBSTX will provide any rebate by applying the full amount due to the first premium payment due on or after August 1 following the end of the MLR reporting year. If the rebate owed is greater than the premium due, BCBSTX will apply any overage to succeeding premium payments until the full amount of the rebate has been credited.

At the time any rebate is provided, BCBSTX will provide to each Participant or former Participant who receives a rebate a notice containing at least the following information:

(A) A general description of the concept of a MLR;
(B) The purpose of setting a MLR standard;
(C) The applicable MLR standard;
(D) BCBSTX's MLR;
(E) BCBSTX's aggregate premium revenue as reported under federal MLR regulations (minus any federal and state taxes and licensing and regulatory fees that may be excluded from premium revenue under those regulations); and
(F) The rebate percentage and amount owed based upon the difference between the BCBSTX's MLR and the applicable MLR standard.

b. Abatement. BCBSTX may from time to time determine to abate (in whole or in part) the premium due under this Contract for particular period(s).

Any abatement of premium by BCBSTX represents a determination by BCBSTX not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Contract. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

c. BCBSTX makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each Participant or former Participant (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

The provisions of this Amendment shall be in addition to (and do not take the place of) the other terms and conditions of this Contract.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Contract to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the date stipulated above.

President of Blue Cross and Blue Shield of Texas

An Amendment

Effective Date September 1, 2011

To be attached to and made a part of your Blue Cross and Blue Shield of Texas* Individual Health Insurance Contract.

Your Contract is amended as follows:

We reserve the right to adjust the premium upon 60 days notice to the Subscriber. Such adjustments in rates shall become effective on the date specified in said notice. This notification is not applicable to rate changes based on attained age or change of residence.

The Prescription Drug Program of Your Contract is amended by adding the following new section.

Benefits for Orally Administered Anticancer Medication

Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Coinsurance or a Copayment Amount will not apply to orally administered anticancer medication listed on the Managed Oral Cancer Drug List. To determine if a specific drug is on the Managed Oral Cancer Drug List, you may access the website at www.bcbstx.com/member/rx_drugs.html or contact Customer Service at the toll-free number on your Identification Card.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Contract to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the date stipulated above.

President of Blue Cross and Blue Shield of Texas

An Amendment

Effective January 1, 2011

To be attached to and made a part of your Blue Cross and Blue Shield of Texas* Individual Plan Insurance Contract.

Your Contract, and any Amendments attached to the Contract, is amended as follows:

1. The Contract renewal date when Your health care coverage under this Contract renews for another Calendar Year is January 1st of each year.

2. The **Benefits Provided Section** of Your Contract is amended by deleting the **Maximum Benefits** subsection in its entirety. Any other Lifetime Maximums, as indicated in Your Contact or amendments attached to Your Contact, are no longer applicable.

3. The definition of **Dependent *child*** in the **Definition Section** of Your Contract is amended to mean a natural child of the Subscriber, a stepchild, or a legally adopted child of the Subscriber (including a child for whom the Subscriber is a party in a suit in which the adoption of the child is being sought), under twenty-six (26) years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors. A grandchild must be dependent on the Subscriber for Federal income tax purposes at the time application for coverage is made to be eligible for coverage under the Contract. Wherever the term **Dependent** is used in Your Contract or any amendments to Your Contract, it will include this change.

4. If Your Contract has a **Rescission of Coverage** provision in the **Standard Provisions Section,** it is amended by deleting the provision in its entirety and replacing it with the following:

   Rescission of Coverage: Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on the Participant's application, will result in the cancellation of Your coverage (and/or Your Dependent(s) coverage) retroactive to the Effective Date, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, Blue Cross and Blue Shield of Texas (BCBSTX) may deduct from the premium refund any amounts made in claim payments during this period and You may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation is effected. At any time when BCBSTX is entitled to rescind coverage already in force, BCBSTX may at its option make an offer to reform the policy already in force. This reformation could include, but not be limited to, the addition of exclusion riders, (this limitation does not apply to a Participant under 19 years of age) and a change in the rating category/level. In the event of reformation, the policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application.

5. The **General Provisions Section** of Your Contract is amended by adding the following new section:

   Policy Year: Policy Year means the 12 month period beginning on January 1 of each year.

Changes in some state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Contract to which this amendment is attached will remain in full force and effect.

President of Blue Cross and Blue Shield of Texas

NOTICE

This health insurance issuer believes this coverage is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits for any individual.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to [P.O. Box 3236, Naperville, Illinois 60566-7236].

You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

An Amendment

To be attached to and made a part of your Blue Cross and Blue Shield of Texas* Individual Health Insurance Contract.

Your Contract, and any Amendments attached to the Contract, is amended as follows:

1. The **Benefits Provided** section of Your Contract is amended by deleting the section **Use of Non-Contracting Providers** in its entirety and replacing it with the following:

   Allowable Amount

   The Allowable Amount is the maximum amount of benefits BCBSTX will pay for Eligible Expenses you incur under the Plan. BCBSTX 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 BCBSTX 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 Plan and any applicable Deductibles, Coinsurance Amounts, and Copayment Amounts.

   Review the definition of Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet to understand the guidelines used by BCBSTX.

2. The **Definitions** section of Your Contract is amended by deleting the definition of Allowable Amount in its entirety and replacing it with the following:

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

   - ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with BCBSTX in Texas 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 in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount) –*** 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 shall 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 shall be not less than 75% and shall be updated on a periodic basis.

When a Medicare reimbursement rate is not available or is unable to be determined based on the information submitted on the claim, the Allowable Amount for non-contracting Providers will represent an average contract rate in aggregate for Network Providers adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall 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 your BCBSTX Identification Card.

- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the *same* day will be the amount for the single procedure with the highest Allowable Amount *plus* a determined percentage of the Allowable Amount ***for each*** of the other covered procedures performed.

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

Except as changed by amendment, all terms, conditions, limitations and exclusions of the Contract to which this Amendment is attached will remain in full force and effect. This amendment shall become effective immediately.

J. Darren Rodgers
President of Blue Cross and Blue Shield of Texas

An Amendment

Effective Date January 1, 2010

To be attached to and made a part of your Blue Cross and Blue Shield of Texas* Individual Health Insurance Contract.

The **Definitions** Section of Your Contract is amended as follows:

By adding the following new definitions:

Research Institution means an institution or Provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under the Plan, without regard to whether the Participant is participating in a clinical trial.

Routine patient care costs do not include:

1. The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. A cost associated with managing a clinical trial; or
5. The cost of a health care service that is specifically excluded from coverage under the Plan.

By adding the following subsection to the definition of **Medical-Surgical Expense**:

Amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:

(1) Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;

(2) Severe food protein-induced enterocolitis syndromes;

(3) Eosinophilic disorders, as evidenced by the results of biopsy; and

(4) Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

A Prescription Order from your Health Care Practitioner is required.

The **Benefits Provided** Section of Your Contract is amended:

By adding the following new sections:

Benefits for Routine Patient Costs for Participants in Certain Clinical Trials

Benefits for Eligible Expenses for Routine Patient Care costs are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:

- the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
- the National Institutes of Health;
- the United States Food and Drug Administration;
- the United States Department of Defense;
- the United States Department of Veterans Affairs; or
- an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

Benefits for Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five (5) years when performed by a laboratory that is certified by a recognized national organization:

(1) Computed tomography (CT) scanning measuring coronary artery calcifications; or
(2) Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each Participant who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Benefits are limited to a $200 maximum benefit amount every five (5) years.

The **Limitations and Exclusions** Section of Your Contract is amended by deleting the exclusion regarding "Fluids, solutions, nutrients, or medications" in its' entirety and substituting the following:

Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting; drugs given through routes other than subcutaneously in the home setting. This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. This exception also does not apply to amino acid-based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins, severe food protein-induced enterocolitis syndromes, eosinophilic disorders, as evidenced by the results of biopsy and disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. A Prescription Order from your Health Care Practitioner is required.

President of Blue Cross and Blue Shield of Texas

ENDORSEMENT

to be inserted in your Contract with

Blue Cross and Blue Shield of Texas, Inc.

Your Contract is amended as follows:

1. The definition of "Dependent" is changed by adding the following:

   The term "Dependent" will also include a child for whom a Participant has received a court order requiring the Participant to have the financial responsibility for providing health insurance. Under the requirements of Section 14.061, *Family Code*, coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage beyond 31 days, application must be made on a form approved by the Carrier and the required premium paid within that 31-day period. If notification is received by the Carrier after the 31-day period, coverage shall be contingent upon application and satisfactory evidence of insurability being submitted to the Home Office of the Carrier. Subject to the Carrier's approval of the application, evidence of insurability, and payment of the first full month's premium, coverage shall become effective of the first day of the month following the date the Carrier approves the application.

2. The following are added under the definition of "Practitioner":

   Licensed Chemical Dependency Counselor

   Licensed Psychological Associate who works under the supervision of a Doctor in Psychology

Blue Cross and Blue Shield of Texas, Inc.
Dallas, Texas

Attest: Jane A. Perkins Secretary Ryper K Coleman President

Form No. 0007.019 Stock No. 0007.019-496

ENDORSEMENT

to the attached

Membership Agreement

Effective August 1, 1994

This Agreement is amended as follows:

The **"Definitions"** article is amended by deleting the definition of **"Practitioner,"** as previously amended, and substituting the following:

> **Practitioner** means a person, when acting within the scope of his license (other than a hospital resident or intern), only as listed:
>
> 1. Doctor of Medicine
> 2. Doctor of Osteopathy
> 3. Doctor of Podiatry
> 4. Doctor of Dentistry
> 5. Doctor of Optometry
> 6. Doctor of Chiropractic
> 7. Doctor in Psychology
> 8. Licensed Audiologist
> 9. Licensed Speech-Language Pathologist
> 10. Licensed Dietitian
> 11. Licensed Master Social Worker-Advanced Clinical Practitioner
> 12. Licensed Professional Counselor
> 13. Licensed Marriage and Family Therapist
> 14. Licensed Hearing Aid Fitter and Dispenser

Such terms as used herein shall have the meaning assigned to them by the *Texas Insurance Code.*

Blue Cross and Blue Shield of Texas, Inc.
Dallas, Texas

President

Attest:

Secretary

ENDORSEMENT

to the attached

Three Hundred Service Membership Agreement

Effective August 1, 1991

This Agreement is amended as follows:

1. This Agreement, which includes coverage for hospital charges for routine well-baby nursery care of a newborn child as part of the mother's hospital charges for the delivery, is changed by deleting this provision in its entirety and substituting the following new provision:

   Hospital charges for routine well-baby nursery care of a newborn child incurred during the mother's hospital admission for the delivery will be considered hospital charges of the child and will be subject to the benefit provisions as described in this Agreement, including, but not limited to, the benefit maximums.

2. The **"Limitations and Exclusions"** article is amended by deleting the wording of Section B, as previously amended, and substituting the following:

   B. Any services or supplies for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law; or 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, except any program which is a state plan for medical assistance (Medicaid); provided, however, this Section B shall not be applicable to any legislation which specifies that the benefits of this Agreement shall be deducted from the benefits available under such legislation.

3. The **"Catastrophic Illness Agreement"** portion is amended in the **"Limitations and Exclusions"** article by deleting the wording of Section C, as previously amended, in its entirety and substituting the following:

   C. Any services or supplies for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law; or 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, except any program which is a state plan for medical assistance (Medicaid); provided, however, this Section C shall not be applicable to any legislation which specifies that the benefits of this Agreement shall be deducted from the benefits available under such legislation.

Blue Cross and Blue Shield of Texas, Inc.
Dallas, Texas

Roger K Coleman
President

Attest: Jean A. Perkins
Secretary

ENDORSEMENT

to the attached

BLUE CROSS MEMBERSHIP AGREEMENT
Effective August 1, 1990

This Agreement is amended as follows:

A. The **"Definitions"** section of this Agreement is changed as follows:

1. By deleting the definition of "Practitioner," as previously amended, in its entirety and substituting the following:

   Practitioner means a person, when acting within the scope of his license (other than a hospital resident or intern), who is a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, Doctor of Chiropractic, Doctor in Psychology, an Audiologist, a Speech-Language Pathologist, a Licensed Dietitian, a Certified Social Worker-Advanced Clinical Practitioner, or a Licensed Professional Counselor. Such terms as used herein shall have the meaning assigned to them by the Insurance Code of Texas.

2. By adding the following new definition:

   Licensed Professional Counselor means a person who is licensed by the Texas State Board of Examiners of Professional Counselors. In states where there is a licensure requirement, the Licensed Professional Counselor must be licensed by the appropriate state administrative agency.

B. The **"Limitations and Exclusions"** section of this Agreement is amended by adding the following new exclusions which are to supersede any existing exclusions which may be in conflict:

1. Any services or supplies provided in connection with an occupational illness 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, or any services or supplies for which benefits are or could upon proper claim be, provided under any other 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, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;

2. Any outpatient counseling and/or therapy, bereavement counseling, vocational counseling, or marital counseling.

C. If a supplementary coverage (Catastrophic Illness Endorsement, Major Medical Endorsement, or Extended Benefits Endorsement) is attached to and made a part of this Agreement, it is amended as follows; otherwise the following amendments have no applicability to this Agreement:

1. The "Benefits" or "Covered Medical Expenses" section of the supplementary coverage shall include:
   a. Services of Practitioners. In the case of a Licensed Dietitian, Certified Social Worker-Advanced Clinical Practitioner, or Licensed Professional Counselor, a professional recommendation must have been obtained from a Doctor of Medicine or a Doctor of Osteopathy.
   b. Services of a Practitioner to restore loss of or correct an impaired speech or hearing function.

2. Any limitations and exclusions to the supplementary coverage shall exclude:
   a. Any services or supplies provided in connection with an occupational illness 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, or any services or supplies for which benefits are or could upon proper claim be, provided under any other 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, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for

hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;

b. Any outpatient counseling and/or therapy, bereavement counseling, vocational counseling, or marital counseling.

Blue Cross and Blue Shield of Texas, Inc.
Dallas, Texas

President

Attest:

Secretary

ENDORSEMENT

to the attached

BLUE SHIELD MEMBERSHIP AGREEMENT
Effective August 1, 1990

This Agreement is amended as follows:

A. The **"Definitions"** section of this Agreement is changed as follows:

1. By deleting the definition of "Practitioner," as previously amended, in its entirety and substituting the following:

   Practitioner means a person, when acting within the scope of his license (other than a hospital resident or intern), who is a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, Doctor of Chiropractic, Doctor in Psychology, an Audiologist, a Speech-Language Pathologist, a Licensed Dietitian, a Certified Social Worker-Advanced Clinical Practitioner, or a Licensed Professional Counselor. Such terms as used herein shall have the meaning assigned to them by the Insurance Code of Texas.

2. By adding the following new definition:

   Licensed Professional Counselor means a person who is licensed by the Texas State Board of Examiners of Professional Counselors. In states where there is a licensure requirement, the Licensed Professional Counselor must be licensed by the appropriate state administrative agency.

B. The **"Limitations and Exclusions"** section of this Agreement is amended by adding the following new exclusions which are to supersede any existing exclusions which may be in conflict:

1. Any services or supplies provided in connection with an occupational illness 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, or any services or supplies for which benefits are or could upon proper claim be, provided under any other 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, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;

2. Any outpatient counseling and/or therapy, bereavement counseling, vocational counseling, or marital counseling.

C. If a supplementary coverage (Catastrophic Illness Endorsement, Major Medical Endorsement, or Extended Benefits Endorsement) is attached to and made a part of this Agreement, it is amended as follows; otherwise the following amendments have no applicability to this Agreement:

1. The "Benefits" or "Covered Medical Expenses" section of the supplementary coverage shall include:
   a. Services of Practitioners. In the case of a Licensed Dietitian, Certified Social Worker-Advanced Clinical Practitioner, or Licensed Professional Counselor, a professional recommendation must have been obtained from a Doctor of Medicine or a Doctor of Osteopathy.
   b. Services of a Practitioner to restore loss of or correct an impaired speech or hearing function.

2. Any limitations and exclusions to the supplementary coverage shall exclude:
   a. Any services or supplies provided in connection with an occupational illness 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, or any services or supplies for which benefits are or could upon proper claim be, provided under any other 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, except any program which is a state plan for medical assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for

Endorsement

to the attached

Blue Cross Membership Agreement

Effective August 1, 1988

This Agreement is amended as follows:

A. The **"Definitions"** section of this Agreement is changed as follows:

1. By deleting the definition of "Practitioner," as previously amended, in its entirety and substituting the following:

   Practitioner means a person, when acting within the scope of his license (other than a hospital resident or intern), who is a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, Doctor of Chiropractic, or a Doctor in Psychology; the term shall not include an Audiologist, a Speech-Language Pathologist, a Licensed Dietitian, or a Certified Social Worker-Advanced Clinical Practitioner. Such terms as used herein shall have the meaning assigned to them by the Insurance Code of Texas.

2. By adding the following new definitions:

   Certified Social Worker-Advanced Clinical Practitioner means a person certified by the Texas Department of Human Resources as a Certified Social Worker with the order of recognition of Advanced Clinical Practitioner. In states where there is a licensure requirement, the Certified Social Worker-Advanced Clinical Practitioner must be licensed by the appropriate state administrative agency.

   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.

   Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ.

   Licensed Dietitian means a person who is licensed by the Texas State Board of Examiners of Dietitians. In states where there is a licensure requirement, the Licensed Dietitian must be licensed by the appropriate state administrative agency.

   Medically Necessary or Medical Necessity means those services or supplies covered hereunder which are:

   1. Essential to, consistent with and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, or injury, or bodily malfunction; and
   2. Consistent with standards of good medical practice; and
   3. Not primarily for the convenience of the Participant, his Practitioner, or other supplier; 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 rendered or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

In determining Medical Necessity, the Plan may consider the views of the state and national medical communities and the views and practices of Medicare, Medicaid, or other government-financed programs. Although a Practitioner or supplier may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Medical Social Services means those social services relating to the treatment of a patient's medical condition. Such services include, but are not limited to (1) assessment of the social and emotional factors related to the patient's sickness, need for care, response to treatment and adjustment to care; and (2) assessment of the relationship of the patient's medical and nursing requirements to the home situation, financial resources, and available community resources.

B. The "**Limitations and Exclusions**" section of this Agreement is amended by adding the following new exclusions which are to supersede any existing exclusions which may be in conflict:

1. Any hospital services or supplies furnished by any institution or facility other than a Member Hospital or a Nonmember Hospital (except that in accident cases, the initial treatment necessary to stabilize the Participant furnished by any governmental or licensed hospital shall be subject to benefits as though such hospital were a Nonmember Hospital);
2. Any services or supplies rendered to any Participant for Dietary and Nutritional Services, except for a nutritional assessment program provided in and by a Member Hospital and approved by Blue Cross and Blue Shield of Texas, Inc.;
3. Any Medical Social Services;
4. Any services or supplies which are not Medically Necessary for the diagnosis or treatment of an illness, injury or bodily malfunction.

C. If a supplementary coverage (Catastrophic Illness Endorsement, Major Medical Endorsement, or Extended Benefits Endorsement) is attached to and made a part of this Agreement, it is amended as follows; otherwise the following amendments have no applicability to this Agreement:

1. The "Benefits" or "Covered Medical Expenses" section of the supplementary coverage shall include services of an Audiologist, a Speech-Language Pathologist, a Dietitian, or a Certified Social Worker-Advanced Clinical Practitioner which are included in the practice of such person in accordance with the applicable license or certification and, in the case of a Dietitian or Certified Social Worker-Advanced Clinical Practitioner, the services have been recommended by a Doctor of Medicine or a Doctor of Osteopathy.

2. Any limitations and exclusions to the supplementary coverage shall exclude:
   a. Any services or supplies rendered to any Participant for Dietary and Nutritional Services, except for a nutritional assessment program provided in and by a Member Hospital and approved by Blue Cross and Blue Shield of Texas, Inc.;
   b. Any Medical Social Services;
   c. Any services or supplies which are not Medically Necessary for the diagnosis or treatment of a covered illness.

D. The "**General Provisions**" section of this Agreement is amended by adding the following new provision:

State Government Programs:

1. Benefits for services or supplies under this Agreement shall not be excluded solely because benefits are paid or payable for such services or supplies under a state plan for medical assistance (Medicaid) made pursuant to 42 U.S.C., Section 1346 et seq., as amended. Any benefits payable under such state plan for medical assistance shall be payable to the Texas Department of Human Services to the extent required by Article 21.49-10 of the Texas Insurance Code.

2. All benefits payable under this Agreement on behalf of a dependent child or children covered by this Agreement, for which benefits for financial and medical assistance are being provided by the Texas Department of Human Services, shall be paid to said department whenever:
   a. The Texas Department of Human Services is paying benefits pursuant to Chapter 31 or 32 of the Human Resources Code, and
   b. The parent who purchased this Agreement has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support.

   The Plan must receive written notice at its Home Office, affixed to the benefit claim when the claim is first submitted, that all benefits claimed must be paid directly to the Texas Department of Human Services.

Blue Cross and Blue Shield of Texas, Inc.
Dallas, Texas

President

Attest: Secretary

Endorsement

to the attached

Blue Shield Membership Agreement

Effective August 1, 1988

This Agreement is amended as follows:

A. The "**Definitions**" section of this Agreement is changed as follows:

1. By deleting the definition of "Practitioner," as previously amended, in its entirety and substituting the following:

   Practitioner means a person, when acting within the scope of his license (other than a hospital resident or intern), who is a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, Doctor of Chiropractic, or a Doctor in Psychology; the term shall not include an Audiologist, a Speech-Language Pathologist, a Licensed Dietitian, or a Certified Social Worker-Advanced Clinical Practitioner. Such terms as used herein shall have the meaning assigned to them by the Insurance Code of Texas.

2. By adding the following new definitions:

   Certified Social Worker-Advanced Clinical Practitioner means a person certified by the Texas Department of Human Resources as a Certified Social Worker with the order of recognition of Advanced Clinical Practitioner. In states where there is a licensure requirement, the Certified Social Worker-Advanced Clinical Practitioner must be licensed by the appropriate state administrative agency.

   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.

   Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ.

   Licensed Dietitian means a person who is licensed by the Texas State Board of Examiners of Dietitians. In states where there is a licensure requirement, the Licensed Dietitian must be licensed by the appropriate state administrative agency.

   Medically Necessary or Medical Necessity means those services or supplies covered hereunder 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. Consistent with standards of good medical practice; and
   3. Not primarily for the convenience of the Participant, his Practitioner, or other supplier; 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 rendered or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

In determining Medical Necessity, the Insurer may consider the views of the state and national medical communities and the views and practices of Medicare, Medicaid, or other government-financed programs. Although a Practitioner or supplier may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Medical Social Services means those social services relating to the treatment of a patient's medical condition. Such services include, but are not limited to (1) assessment of the social and emotional factors related to the patient's sickness, need for care, response to treatment and adjustment to care; and (2) assessment of the relationship of the patient's medical and nursing requirements to the home situation, financial resources, and available community resources.

Reasonable Charge means the actual charge, or portion thereof, for a service or supply to the extent such service or supply is reasonably priced in the light of the sickness or injury being treated.

A charge is reasonable if the Insurer has compiled significant statistical data on the service or supply and based on that data the charge is not greater than the Insurer's then established percentile of the range of the charges for the same service or supply customarily made by providers of care in the locality with similar training, experience and facilities. The Insurer may, at its option, allow a higher charge if it deems it reasonable.

In making a determination of Reasonable Charge, the Insurer shall consider unusual circumstances or medical complications requiring additional time, skill, experience and facilities in connection with a particular service, which are specifically brought to the Insurer's attention.

B. The "**Schedule of Benefits**" section is amended by adding the following new benefit section:

Mammography Screening Benefit: If a female Participant 35 years of age or older receives radiological services for screening by low-dose mammography for the presence of occult breast cancer, the Insurer will pay the Reasonable Charge for such services. Benefits shall not be payable for more than one mammography screening per Contract Year.

C. The "**Limitations and Exclusions**" section of this Agreement is amended by adding the following new exclusions which are to supersede any existing exclusions which may be in conflict:

1. Any services or supplies rendered by a Practitioner in connection with a routine physical examination or diagnostic screening, except for mammography screening as provided in this Agreement; or any services or supplies which are not Medically Necessary for the diagnosis or treatment of a sickness, injury or bodily malfunction;

2. Any care for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law, or any other 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;

3. Any services or supplies rendered to any Participant for Dietary and Nutritional Services;

4. Any Medical Social Services.

D. The "**General Provisions**" section of this Agreement is amended by adding the following new provision:

State Government Programs:

1. Benefits for services or supplies under this Agreement shall not be excluded solely because benefits are paid or payable for such services or supplies under a state plan for medical assistance (Medicaid) made pursuant to 42 U.S.C., Section 1346 et seq., as amended. Any benefits payable under such state plan for medical assistance shall be payable to the Texas Department of Human Services to the extent required by Article 21.49-10 of the Texas Insurance Code.

2. All benefits payable under this Agreement on behalf of a dependent child or children covered by this Agreement, for which benefits for financial and medical assistance are being provided by the Texas Department of Human Services, shall be paid to said department whenever:

   a. The Texas Department of Human Services is paying benefits pursuant to Chapter 31 or 32 of the Human Resources Code, and

   b. The parent who purchased this Agreement has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support.

   The Insurer must receive written notice at its Home Office, affixed to the benefit claim when the claim is first submitted, that all benefits claimed must be paid directly to the Texas Department of Human Services.

Group Life and Health Insurance Company
Dallas, Texas

President

Attest: Secretary

Endorsement

to the attached

Blue Cross Membership Agreement

Effective March 1, 1986

This Agreement is amended as follows:

A. Wherever used in this Agreement, the name Group Hospital Service, Inc. is changed to Blue Cross and Blue Shield of Texas, Inc.

B. Wherever the term "physician" appears in this Agreement, the term "practitioner" is deemed to be substituted in its place.

C. The "Definitions" section of this Agreement is amended by deleting the definition of "Physician" in its entirety and substituting the following:

Practitioner means a person, when acting within the scope of his license (other than a hospital resident or intern), who is a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, Doctor of Chiropractic, or a Doctor in Psychology; the term shall not include an audiologist or speech-language pathologist. Such terms as used herein shall have the meaning assigned to them by the Insurance Code of Texas.

D. If a supplementary coverage (Catastrophic Illness Endorsement, Major Medical Endorsement, or Extended Benefits Endorsement) is attached to and made a part of this Agreement, it is amended as follows; otherwise the following amendments have no applicability to this Agreement:

1. The "Benefits" or "Covered Medical Expenses" section of the supplementary coverage shall include services of an audiologist or speech-language pathologist which are included in the practice of such practitioners as defined in Article 4512j of Vernon's Civil Statutes (1984 Supp.) of the State of Texas.

2. Any limitations and exclusions to the supplementary coverage shall exclude:

   a. Artificial devices used for the purpose of enhancing any one or more of the senses, including but not limited to, eyeglasses (including contact lenses) and hearing aids, or examinations for the prescription or fitting thereof;

   b. Any services or supplies rendered in connection with a routine physical examination or diagnostic screening; or any services or supplies which are not medically necessary for the diagnosis or treatment of an illness, injury or bodily malfunction.

3. The following new definitions shall be applicable to the supplementary coverage:

   Audiologist means a person who has received a master's or doctorate degree in audiology from an accredited college or university and who is certified by the American Speech-Language and Hearing Association. In states where there is a licensure requirement, the audiologist must be licensed by the appropriate state administrative agency.

   Speech-Language Pathologist means a person who has received a master's or doctorate degree in speech pathology or speech-language pathology from an accredited college or university and who is certified by the American Speech-Language and Hearing Association. In states where there is a licensure requirement, the speech-language pathologist must be licensed by the appropriate state administrative agency.

Blue Cross and Blue Shield of Texas, Inc.
Dallas, Texas

President

Attest: Secretary

Endorsement

to the attached

Blue Shield Membership Agreement

Effective March 1, 1986

This Agreement is amended as follows:

A. Wherever the term "physician" appears in this Agreement, the term "practitioner" is deemed to be substituted in its place.

B. The "Definitions" section of this Agreement is amended by deleting the definition of "Physician" in its entirety and substituting the following:

Practitioner means a person, when acting within the scope of his license (other than a hospital resident or intern), who is a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, Doctor of Chiropractic, or a Doctor in Psychology; the term shall not include an audiologist or speech-language pathologist. Such terms as used herein shall have the meaning assigned to them by the Insurance Code of Texas.

C. The "Limitations and Exclusions" section of this Agreement is amended by deleting the following exclusion:

Any services rendered in connection with a routine physical examination, or any diagnostic or evaluation procedures not necessary to the proper treatment of an abnormal physical or mental condition,

and substituting the following new exclusion:

Any services or supplies rendered by a practitioner in connection with a routine physical examination or diagnostic screening; or any services or supplies which are not medically necessary for the diagnosis or treatment of an illness, injury or bodily malfunction.

Group Life & Health Insurance Company
Dallas, Texas

President

Attest: Secretary

ENDORSEMENT

to the attached

BLUE CROSS MEMBERSHIP AGREEMENT

EXTENDING COVERAGE FOR DEPENDENT CHILDREN WHO ARE MENTALLY RETARDED OR PHYSICALLY HANDICAPPED

Coverage for any disabled child who is otherwise eligible for coverage under this agreement, and for whose coverage application has been made by the Member and accepted by the Plan, may be continued for the period of such disability beyond the maximum age; provided that the child is dependent upon the Member for more than one-half of his support as defined by the Internal Revenue Code of the United States.

"Maximum Age" as used in this endorsement, means the age upon which a child otherwise ceases to be eligible for any coverage under the terms of this agreement.

"Disabled" means any medically determinable physical or mental condition which prevents the child from engaging in self-sustaining employment; provided that the disability commences prior to such child's attainment of the maximum age and that satisfactory proof of such disability and dependency is submitted by the Member within thirty-one (31) days following such child's attainment of the maximum age.

As a condition to the continued coverage of a disabled child beyond the maximum age, the Plan shall have the right to require periodic certification of the child's physical or mental condition and dependency, but not more frequently than annually after the two-year period following the child's attainment of the maximum age.

GROUP HOSPITAL SERVICE, INC.
DALLAS, TEXAS

President

ATTEST:

Secretary

Stock No. 6782.000-N181

ENDORSEMENT

to the attached

BLUE CROSS MEMBERSHIP AGREEMENT

Effective September 1, 1980

1. This Agreement is amended to provide that benefits for services or supplies shall not be excluded solely because benefits are paid or payable for such services or supplies under the Medical Assistance Act of 1967, as amended, and to further provide that benefits shall be payable to the Texas State Department of Human Resources to the extent required by the provisions of Chapter 783, Acts of the 66th Legislature, 1979.

2. The definition of "Physician" is amended to read as follows:

   "Physician" means a person (other than a hospital resident or intern) who is a Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, or Doctor of Chiropractic, or a psychologist who is certified and licensed by the Texas State Board of Examiners of Psychologists under Article 4512c of Vernon's Civil Statutes of the State of Texas, Annotated. The terms Doctor of Medicine, Doctor of Osteopathy, Doctor of Podiatry, Doctor of Dentistry, Doctor of Optometry, and Doctor of Chiropractic as used herein, shall have the meaning assigned to them by the Insurance Code of Texas.

GROUP HOSPITAL SERVICE, INC.
DALLAS, TEXAS

President

ATTEST:

Secretary

Form No. 9468

STOCK NO. 9468.000-N183

ENDORSEMENT

to the attached

MEDICAL-SURGICAL INSURANCE POLICY

Effective July 1, 1976

for

EFFECTIVE DATE OF COVERAGE OF NEWBORN CHILDREN

Coverage of dependent children who are born after the effective date of this Policy shall be in effect from the date of birth through the thirty-first (31st) day following the date of birth, provided that for coverage to be in effect following such thirty-first (31st) day, the Policyholder must:

(a) either submit notification of the birth of such child within thirty-one (31) days following birth or show that it was not reasonably possible to submit notification within thirty-one (31) days following eligibility and that the notification was submitted as soon as was reasonably possible and in no event, except in the absence of legal capacity, later than thirteen (13) months from the date of birth, and

(b) remit all premiums due from the first day of the policy month following the date of birth to the second premium due date following the date such notification is submitted.

Coverage under this Policy shall include benefits for services and supplies rendered to a newborn child which are necessary for treatment or correction of a congenital defect, subject to all other terms and provisions of the Policy.

GROUP LIFE & HEALTH
INSURANCE COMPANY
Dallas, Texas

President

ATTEST:

Secretary

Stock No. 6360.000-285

Endorsement

to the attached

Blue Cross Membership Agreement

Effective July 1, 1976

for

1. Effective Date of Coverage of Newborn Children

Coverage of dependent children who are born after the effective date of this Agreement shall be in effect from the date of birth through the thirty-first (31st) day following the date of birth, provided that for coverage to be in effect following such thirty-first (31st) day, the Member must:

(a) either submit notification of the birth of such child within thirty-one (31) days following birth or show that it was not reasonably possible to submit notification within thirty-one (31) days following eligibility and that the notification was submitted as soon as was reasonably possible and in no event, except in the absence of legal capacity, later than thirteen (13) months from the date of birth, and

(b) remit all premiums due from the first day of the contract month following the date of birth to the second premium due date following the date such notification is submitted.

Coverage under this Agreement shall include benefits for services and supplies rendered to a newborn child which are necessary for treatment or correction of a congenital defect, subject to all other terms and provisions of this Agreement.

2. Inclusion of Coverage For Blood and Plasma

Benefits will be provided for blood and plasma, including cross-matching and blood typing, when provided by a member or nonmember hospital and received by a participant during an outpatient visit, or a day of bed-patient hospital care, for which benefits are available under the terms and provisions of this Agreement.

Blue Cross and Blue Shield of Texas, Inc.
Dallas, Texas

President

Attest:

Secretary

Stock No. 6359.000-984

ENDORSEMENT

to the attached

BLUE SHIELD MEMBERSHIP AGREEMENT

EXTENDING COVERAGE FOR DEPENDENT CHILDREN WHO ARE MENTALLY RETARDED OR PHYSICALLY HANDICAPPED

Coverage for any disabled child who is otherwise eligible for coverage under this agreement, and for whose coverage application has been made by the Policyholder and accepted by the Insurer, may be continued for the period of such disability beyond the maximum age; provided that the child is dependent upon the Policyholder for more than one-half of his support as defined by the Internal Revenue Code of the United States.

"Maximum Age" as used in this endorsement, means the age upon which a child otherwise ceases to be eligible for any coverage under the terms of this agreement.

"Disabled" means any medically determinable physical or mental condition which prevents the child from engaging in self-sustaining employment; provided that the disability commences prior to such child's attainment of the maximum age and that satisfactory proof of such disability and dependency is submitted by the Policyholder within thirty-one (31) days following such child's attainment of the maximum age.

As a condition to the continued coverage of a disabled child beyond the maximum age, the Insurer shall have the right to require periodic certification of the child's physical or mental condition and dependency, but not more frequently than annually after the two-year period following the child's attainment of the maximum age.

GROUP LIFE & HEALTH INSURANCE COMPANY
DALLAS, TEXAS

President

ATTEST:

Secretary

9037.000-N1271

BlueCross BlueShield of Texas

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

BlueCross BlueShield of Texas

中文 Chinese	注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujurati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر [وارد کردن زبان] صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (TTY: 711) 855-710-6984 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

YOUR RIGHTS WITH A PREFERRED PROVIDER BENEFIT PLAN (PPO)

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

Health care costs

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

List of doctors

You can get a directory of health care providers that are in your plan's network.
You can get the directory online at www.bcbstx.com or by calling 1-800-521-2227.
If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Health care bills

If you want to see a doctor or facility that isn't in your plan's network, you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay.
If you received health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you received emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.
If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Mastectomy or Lymph Node Dissection

Minimum Inpatient Stay: If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and
(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the covered person receiving the treatment and the attending Physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending Physician, or otherwise penalize the Physician, because the Physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending Physician to encourage the Physician to provide care that is less than the minimum hours.

Coverage and/or Benefits for Reconstructive Surgery After Mastectomy-Annual

Your contract, as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Examinations for Detection of Prostate Cancer

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include:

(a) a physical examination for the detection of prostate cancer; and

(b) a prostate-specific antigen test for each covered male who is

(1) at least 50 years of age; or

(2) at least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay following Birth of a Child

If your plan includes Maternity Coverage, for each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery, and

(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a Hospital or other health care facility or (b) remain in a Hospital or other health care facility for the minimum numbers of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a Physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health facility.

Since we provide in-home post-delivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's Physician determines the inpatient care is Medically Necessary, or (b) the mother requests the inpatient stay.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a Physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the Physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a Physician for recommending inpatient care for the mother and/or newborn child.

Coverage 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 45 years of age or older and who are at normal risk for developing colon cancer:

(a) All colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and

(b) An initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal.

Benefits provided above by an In-Network Provider will not be subject to a Deductible, Copayment Amounts, or Coinsurance Amounts.

Benefits provided above by an Out-of-Network Provider will be subject to any applicable Deductible, Copayment Amounts, or Coinsurance Amounts.

Coverage of Tests for Detection of Human Papillomavirus, Ovarian Cancer, and Cervical Cancer

Coverage is provided for each woman enrolled in the plan who is 18 years of age or older for expenses incurred for an annual, medically recognized diagnostic examination for the early detection of ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test

and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

Treatment of Acquired Brain Injury

Your Health Benefit Plan coverage for an acquired brain injury includes the following services:

(a) cognitive rehabilitation therapy;
(b) cognitive communication therapy;
(c) neurocognitive therapy and rehabilitation;
(d) neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;
(e) neurofeedback therapy, Remediation;
(f) post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
(g) reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive Rehabilitation Services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services commensurate with their condition. Post-acute care treatment or services may be obtained in any facility where such services may legally be provided, including acute or post-acute rehabilitation Hospitals and assisted living facilities regulated under the Health and Safety Code.

If any person covered by this plan has questions concerning the information above, please call Blue Cross and Blue Shield of Texas at 1-888-521-2227 or write us at P.O. Box 660044, Dallas, Texas 75266-0044.

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
  - Up to $500,000 for health benefit plans, with some exceptions.
  - Up to $300,000 for disability income benefits.
  - Up to $300,000 for long-term care insurance benefits.
  - Up to $200,000 for all other types of health insurance.
- **Life insurance:**
  - Up to $100,000 in net cash surrender or withdrawal value.
  - Up to $300,000 in death benefits.
- **Individual annuities:** Up to $250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to $300,000 per person, regardless of the number of policies or contracts. A limit of $500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:	For questions about insurance, contact:
Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, TX 78701 1-800-982-6362 or www.txlifega.org	**Texas Department of Insurance** P.O. Box 149104 Austin, TX 78714-9104 1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Texas Department of Insurance Notice

- You have the right to an adequate network of preferred Providers (also known as "network Providers").
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.
  - If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and Out-of-Pocket Maximum.

- You have the right, in most cases, to obtain estimates in advance:
  - from out-of-network Providers of what they will charge for their services; and
  - from your insurer of what it will pay for the services.

- You may obtain a current directory of preferred Providers at the following website: www.bcbstx.com or by calling the Customer Service number on the back of your ID card for assistance in finding available preferred Providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

- If you are treated by a Provider or Hospital that is not a preferred Provider, you may be billed for anything not paid by the insurer.

NOTICE OF APPEAL RIGHTS

(Retain for your records)

If Blue Cross and Blue Shield of Texas (BCBSTX) has declined your application for health insurance coverage or issued you a policy with a rider, then this document serves as part of your notice of an initial adverse determination. **Contact us at the number below, if you need assistance understanding this notice or your adverse determination.**

Any conflicts between the statements below and rights stated elsewhere in this notice (or, if applicable, in your policy), will be resolved so that those rights that are more beneficial to you will apply, unless the law requires otherwise.

Your Internal Appeal Rights

What if I don't agree with this decision? You have a right to appeal an adverse determination. We will provide a full and fair review of your appeal by individuals associated with us, but who were not involved in making the initial adverse determination.

Who may file an internal appeal? You or someone you name to act for you (your authorized representative) may file an appeal. You may designate an authorized representative by completing the necessary forms. For more information on how to do so, contact us at the number below.

How do I file an internal appeal? You may contact us at the number below and request an internal appeal or send a written request to:

Blue Cross and Blue Shield of Texas
P.O. Box 3122
Naperville, Illinois 60566-9744
Phone: (866)520-2507
Fax: (888)235-2936

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will be completed within 72 hours of our receipt of your appeal. An urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your doctor you experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal.

Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information that relates to your claim once you initiate your appeal. You may also have the option of presenting evidence and testimony. In addition, we will provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination so you have a sufficient time to respond before a final decision is made.

Can I request copies of information relevant to my claim? Yes, you may request and receive copies relevant to your claim free of charge. For example, upon request, you will receive any applicable diagnosis and treatment codes (and their corresponding meanings) associated with an adverse determination. In addition, if we rely on a rule or guideline in making an adverse determination, we will provide that rule or guideline to you free of charge upon request. You can request copies of this information by contacting us at the number above.

What happens next? If you appeal, we will review our decision and send you a written determination within 30 days of receiving your appeal.

Note: Individual plans with an effective date on or after March 23, 2010, will receive only one level of internal review. **Contact us at the number on the back of your ID card if you need assistance in understanding this notice or adverse determination.**

Other Resources to Help You

For questions about your rights, this notice, or for assistance, you can contact the Texas Consumer Health Assistance Program at:

Texas Consumer Health Assistance Program
Texas Department of Insurance
Mail Code 111-1A, 333 Guadalupe
P.O. Box 149091
Austin, Texas 78714
www.texashealthoptions.com
Telephone: (855)839-2427
Email: chap@tdi.state.tx.us

You may be eligible to receive your adverse determination and this notice in a language listed below. In addition, you may call us to receive assistance in these languages.

SPANISH (Español): Para asistencia en Español, por favor llame al numero ubicado en la parte posterior de su tarjeta de identificación.

TAGALOG (Tagalog): Upang humingi ng tulong sa Tagalog, paki tawagan ang numero na nakasulat sa inyong kard.

CHINESE (中文): 如果需要中文幫助，請撥打您卡上的電話號碼。

NAVAJO (Dine): Dinék'ehjí áka'a'doowoo ł biniiyé, t'áá shǫǫdi kojį' hodíílnih béésh bee hane'í bi numbo bee néé ho'dólzinígíí biniiyé nanitinígíí bine'dęę' bikáá'.

Notice Regarding Your Benefits

This notice is to inform you that changes have been made to your coverage that may add certain new women's preventive benefits beginning August 1, 2012. The changes are generally outlined below. Blue Cross and Blue Shield of Texas (BCBSTX) will send you an amendment once it has been approved by the Texas Department of Insurance.

Women's Preventive Coverage

Certain preventive health services may now be covered with no patient cost-sharing (such as no copayment, coinsurance or deductible) when using a contracting provider within the BCBSTX provider network.

Subject to the terms and conditions of coverage in your policy, these may include:

- Well-woman visits
- Screening for diabetes during pregnancy
- HPV testing for women at least 30 years of age
- Counseling for sexually transmitted infections
- HIV screening and counseling
- FDA-approved contraception methods, sterilization procedures and counseling (see below for more details)
- Breastfeeding support, supplies and counseling
- Interpersonal relations and domestic violence screening and counseling

FDA-approved contraception methods, sterilization procedures and counseling

We may be adding coverage of certain contraceptive medicines, devices and procedures to your policy benefits. They may be covered with no cost-sharing when the services are provided by a BCBSTX network provider. Please note that the coverage of women's contraceptives with no cost-sharing may be limited to certain medicines, devices and procedures within the following categories:

- Designated prescription contraception drugs
- Over-the-counter contraceptives for women (foam, sponge, female condoms) when prescribed by a physician
- Designated medical devices such as certain IUDs, diaphragms, cervical caps and contraceptive implants
- Female sterilization procedures (hysterectomies are not considered part of the women's preventive care benefit as described in this letter)

Please refer to your plan materials or contact us at the phone number on your member ID card for more information. Please remember that the terms and conditions of your policy determine your benefits. In the event of a conflict between this notice and your policy, the policy will supersede this notice.

We appreciate your business and look forward to serving you.

Health Care Service Corporation, a Mutual Legal Reserve Company, does business through its corporate divisions, Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Texas and Blue Cross and Blue Shield of New Mexico. Health Care Service Corporation is an independent organization governed by its own Board of Directors and is solely responsible for its own debts and other obligations.

The Blue Cross and Blue Shield Association licenses Health Care Service Corporation to offer certain products and services under the Blue Cross and Blue Shield brand names.

Neither the Association nor any other organization using the Blue Cross or Blue Shield brand names acts as a guarantor of Health Care Service Corporation's obligations.

A copy of Health Care Service Corporation's most recent audited financial statement is available upon written request to Public Affairs/Consolidated Balance Sheet, Health Care Service Corporation, 300 East Randolph Street, 19th Floor, Chicago, Illinois 60601.

Health Care Service Corporation and Subsidiaries

Condensed consolidated balance sheet, December 31, 2002
(In Thousands of Dollars)

ASSETS	
Cash & Investments	$3,499,379
Premiums & Other Receivables	1,107,564
Property & Equipment	259,665
Other Assets	562,745
Total Admitted Assets	$5,429,353

LIABILITIES & NET WORTH	
Claim Reserves	$1,134,866
Aggregate Reserves	990,611
Accounts Payable & Other Liabilities	1,431,332
Long-Term Debt	399,766
Total Liabilities	$3,956,575
Minority Interest	12,000
Statutory Net Worth	$1,460,778
Total Liabilities & Net Worth	$5,429,353

This statement is for information only. No action is required.

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event provided by Medicare

Medicare generally pays for most of all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance , review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

0002.723-95 Stock Number 0002.723-795

NOTICE

THIS CONTRACT IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" (Buyer's Guide) which you may obtain by calling Blue Cross and Blue Shield of Texas, Inc. at the following telephone numbers:

1-800-338-2227 toll free
Dallas area: (214) 669-3926

or you may write to them at P. O. Box 655730, Dallas, Texas 75265-5730.

Form No. 4859 Stock No. 4859.000-292

Assumption Certificate

This is to certify that:

Blue Cross and Blue Shield of Texas, Inc. of Dallas, Texas, has assumed all liability for benefits payable under the Subscriber's contract initially issued by Group Life and Health Insurance Company or jointly by Blue Cross and Blue Shield of Texas, Inc. (formerly Group Hospital Service, Inc.) and Group Life and Health Insurance Company.

Wherever the term "Carrier" is used in the Subscriber's contract, it shall mean Blue Cross and Blue Shield of Texas, Inc. Any reference to Blue Cross of Texas, Blue Shield of Texas, Group Hospital Service, Inc., or Group Life and Health Insurance Company shall be deemed to have no meaning other than Blue Cross and Blue Shield of Texas, Inc.

In testimony whereof, for Blue Cross and Blue Shield of Texas, Inc., I have duly executed this Assumption Certificate.

President