Note: This Contract is subject to: (1) maximum lifetime benefits; (2) premium increases as specified in Article VIII; (3) termination of coverage in accordance with Article VI, and (4) precertification requirements.

NOTICE OF TEN-DAY RIGHT TO EXAMINE CONTRACT

Within ten days after its delivery to You, this Contract may be surrendered by delivering or mailing it to Us at Our Administrative Office, branch office, or agent through whom it was purchased. Upon such surrender, any premiums paid will be returned.

Blue Cross and Blue Shield of Texas*

Herein called (We, Us, Our)
Administrative Office: Richardson, Dallas County, Texas

Has issued this individual

PREFERRED PROVIDER CONTRACT

providing

Comprehensive Major Medical Expense Coverage

To

The Subscriber named on the Identification Card enclosed with this Contract.

This Contract is effective from 12:01 a.m. on the Effective Date shown on the Identification Card.

In Consideration of the payment of premiums in accordance with the provisions hereof, We agree to provide benefits to the Subscriber under the terms of this Contract as recited on this and the following pages from the Effective Date of this Contract and for consecutive premium payment periods thereafter, unless this Contract is terminated as provided in Article VI.

This Contract is issued in the State of Texas and is governed in accordance with the laws of this State.

Please review this Contract carefully. It details the necessary requirements and procedures that are important for You to know to receive maximum benefits under this Contract.

President

THIS IS NOT A CONTRACT OF WORKERS'COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS CONTRACT, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

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

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 12030
  Austin, Texas 78711-2030
  Fax: (512) 490-1007
  Web: 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 12030
  Austin, Texas 78711-2030
  Fax: (512) 490-1007
  Web: 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.

Table of Contents

Article I — Definitions

As used in this Contract:

1. **Accidental Injury** means an accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider within 30 days after the occurrence.

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

   a. ***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.

   b. ***For Hospitals and Facility Other Providers not contracting with Us in Texas or any other Blue Cross and Blue Shield Plan outside of Texas*** – The Allowable Amount will be the amount BCBSTX would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate, the Allowable Amount will be the lesser of billed charge or a per diem established by BCBSTX.

   c. ***For procedures, services or supplies provided in Texas by Physicians and Professional Other Providers not contracting with Us*** – The Allowable Amount shall be the lesser of the billed charge or the amount We would have considered for payment for the same covered procedure, service or supply if performed or provided by a Physician or Professional Other Provider with similar experience and/or skill. If We do not have sufficient data to calculate the Allowable Amount for a particular procedure, service or supply, We will determine an Allowable Amount based on the complexity of the procedure, service or supply and any unusual circumstances or medical complications specifically brought to Our attention, which require additional experience, skill and/or time.

   d. ***For procedures, services or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with Us, or any other Blue Cross and Blue Shield Plan*** – We will establish an Allowable Amount using, at Our option Texas regional; or state allowable applicable to procedures, services or supplies of Physicians or Professional Other Providers with similar skills and experience.

   e. ***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* one-half of the Allowable Amount *for each* of the other procedures performed.

   f. ***For drugs administered by a Home Infusion Therapy Provider*** – The Allowable Amount will be the lesser of (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark down from the AWP wholesale price established by BCBSTX and updated on a periodic basis.

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

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

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

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

a. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells); or

b. Urine auto injection (injecting one's own urine into the tissue of the body); or

c. Skin irritation by Rinkel method; or

d. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or

e. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

7. **Coinsurance Amount** means the cumulative dollar amount of Eligible Expenses incurred by a Participant during a Calendar Year to be applied toward the Coinsurance Amount Stop-Loss benefits as described in the Coinsurance Stop-Loss section in Article IV of this Contract.

8. **Complications of Pregnancy** means:

   a. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

   b. Termination of pregnancy by nonelective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

9. **Compound Drugs** means those drugs which meet the following requirements:

   a. The drugs in the compounded product have to be Food and Drug Administration (FDA) approved; and

   b. The approved product must have an assigned National Drug Code (NDC).

10. **Contract Month** means each succeeding monthly period beginning on the Effective Date.

11. **Copayment Amount** means the payment, as expressed in dollars, which must be made by or on behalf of a Participant for certain services at the time they are provided. In the case of Copayment Amount in reference to the Prescription Drug Program, the fixed dollar amount paid by the Participant for each Prescription Order dispensed or refilled at a Participating Pharmacy.

12. **Cosmetic, Reconstructive or Plastic Surgery** means surgery that:

    a. Can be expected or is intended to improve the physical appearance of a Participant; or

    b. Is performed for psychological purposes; or

    c. Restores form but does not correct or materially restore a bodily function.

13. **Covered Drugs** means any Legend Drug or injectable drug, including insulin, disposable syringes and needles needed for self-administration:

    a. Which is Medically Necessary and is ordered by a Provider naming a Participant as the recipient;

    b. For which a written or verbal Prescription Order is prepared by a Provider;

    c. For which a separate charge is customarily made;

    d. Which is not entirely consumed at the time and place that the Prescription Order is written;

    e. For which the Food and Drug Administration (FDA) has given approval for at least one indication; and

    f. Which is dispensed by a Pharmacy and is received by the Participant while covered under this Contract, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other acute care institution or facility.

14. **Creditable Coverage** means coverage under any one of the following:

    a. A self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or

b. Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; or

c. Part A or Part B of Title XVIII of the Social Security Act (Medicare); or

d. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; or

e. Chapter 55 of Title 10, United States Code; or

f. A medical care program of the Indian Health Service or of a tribal organization; or

g. A state health benefits risk pool; or

h. A plan offered under Chapter 89 of Title 5, United States Code; or

i. A public health plan as defined by federal regulations; or

j. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C., Section 2504(e)); or

k. Short-term limited duration coverage.

Creditable Coverage does not include:

(1) Accident only, disability income insurance, or a combination thereof;

(2) Coverage issued as a supplement to liability insurance;

(3) Liability insurance, including general liability insurance and automobile liability insurance;

(4) Workers' Compensation or similar insurance;

(5) Credit-only insurance;

(6) Coverage for onsite medical clinics;

(7) Coverage for limited-scope dental or vision benefits;

(8) Long-term care, nursing home care, home health care, or community-based care coverage or benefits, or any combination thereof;

(9) Coverage for a specified disease or illness;

(10) Hospital indemnity or other fixed indemnity insurance; or

(11) Medicare supplemental health insurance, supplemental to the group coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et. seq.), and similar supplemental coverage provided under a group plan; and

(12) Other similar coverage specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(13) Automobile payment insurance

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

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

17. **Dependent** means:

a. A Subscriber's spouse; or
b. Any unmarried child who is under 23 years of age.

Child means:

(1) The natural child of the Subscriber; or

(2) 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); or

(3) A stepchild of the Subscriber whose primary residence is the Subscriber's household; or

(4) A child for whom the Subscriber has received a court order or an order requiring that Participant have financial responsibility for providing health insurance; or

(5) A grandchild of the Subscriber who is dependent upon the Subscriber for Federal income tax purposes.

18. **Dietary and Nutritional Services** means the education, counseling, or training of a Participant (including printed material) regarding (a) diet; (b) regulation or

management of diet; or (c) the assessment or management of nutrition.

19. **Durable Medical Equipment Provider** means a Provider that provides therapeutic supplies and rehabilitative equipment.

20. **Eligible Expenses** means either *Inpatient Hospital Expense, Medical-Surgical Expense,* or *Extended Care Expense*, all as specified in Article IV, Section 1 of this Contract.

21. **Emergency Care** means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

    a. Placing the patient's health in serious jeopardy;

    b. Serious impairment to bodily functions,

    c. Serious dysfunction of any bodily organ or part,

    d. Serious disfigurement, or

    e. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

    a. Controlled environment; or

    b. Sanitizing the surroundings, removal of toxic materials; or

    c. Use of special nonorganic, non-repetitive diet techniques.

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

    As used herein, ***medical treatment*** includes medical, surgical or dental treatment. ***Standard medical treatment*** means the services or supplies that are in general use in the medical community in the United States, and:

    a. Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;

    b. Are appropriate for the Hospital or Facility Other Provider in which they were performed; and

    c. The Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

    Our medical staff shall determine whether any treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider the guidelines and practices of Medicare, Medicaid or other government-financed programs in making Our determination.

    Although a Physician or Professional Other Provider may have prescribed treatment and the services or supplies may have been provided as the treatment of last resort, We still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

24. **Extended Care Expense** means the services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in this Contract.

25. **Generic Drug** means a drug, which is pharmaceutically and therapeutically equivalent to the brand name drug prescribed.

26. **Generic Drug Copayment Amount** means the Copayment Amount applicable when a Generic Drug is dispensed. This Copayment Amount is less than the Preferred Drug Copayment Amount and Non-Preferred Drug Copayment Amount.

27. **Health Status Related Factor** means:

    a. Health status

    b. Medical condition, including both physical and mental illness;

c. Claims experience;

d. Receipt of health care;

e. Medical history;

f. Genetic information;

g. Evidence of insurability, including conditions arising out of acts of family violence; and

h. Disability.

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

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

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

    a. Drugs and IV solutions;

    b. Pharmacy compounding and dispensing services;

    c. All equipment and ancillary supplies necessitated by the defined therapy;

    d. Delivery services;

    e. Patient and family education;

    f. Nursing services.

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

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

32. **Hospice** means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which:
    a. Is licensed in accordance with state law (where the state law provides for such licensing); and

    b. Is certified by Medicare as a supplier of Hospice Care.

33. **Hospice Care** means services for which benefits are provided under this Contract when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

34. **Hospital** means a short-term acute care facility which:

    a. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, or is certified as a Hospital provider under Medicare;

    b. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;

    c. Has organized departments of medicine, diagnostic, major surgery, and maintains clinical records on all patients;

    d. Provides 24-hour nursing services by or under the supervision of a registered nurse;

    e. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, custodial care home, health resort, spa or sanitarium, place for rest, place for the aged, or a Hospice.

35. **Hospital Admission** means the period between the time of a Participant's entry into a Hospital as a bed patient and the time of discontinuance of bed-patient care or discharge by the admitting Physician or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time he is confined in the Hospital, We shall consider the admission a Hospital Admission.

    Bed patient means confinement in a bed accommodation located in a portion of a Hospital which is designed,

staffed and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital designed, staffed and operated to provide long-term institutional care on a residential basis.

36. **Identification Card** means the card issued to the Subscriber indicating pertinent information applicable to his coverage under this Contract, including applicable Copayment Amounts.

37. **Imaging Center** means a Facility Other Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.

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

39. **Inpatient Hospital Expense** means charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant; provided that such items are: (a) furnished at the direction or prescription of a Physician or Professional Other Provider; (b) provided by a Hospital; and (c) furnished to and used by the Participant during a Hospital Admission.

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

    a. Room and board charges. If the Participant is confined in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge will *not* be an Eligible Expense.

    b. All other usual Hospital services which are Medically Necessary and consistent with the condition of the Participant. Personal items are *not* included as Eligible Expenses.

40. **Legend Drugs** means drugs, biologicals, or compound prescriptions which are required by law to have a label stating "Caution—Federal Law Prohibits Dispensing Without a Prescription" and which are approved by the U.S. Food and Drug Administration (FDA) for a least one indication.

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

42. **Maternity Care** means care and services provided for treatment of the condition of pregnancy, other than Complications of Pregnancy.

43. **Medical Social Services** means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to:

    a. Assessment of the social and emotional factors related to the Participant's sickness, need for care, response to treatment and adjustment to care; and

    b. Assessment of the relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

44. **Medical-Surgical Expense** means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are: (a) furnished by or at the direction or prescription of a Physician or Professional Other Provider; and (b) not included as an item of *Inpatient Hospital Expense* or *Extended Care Expense* in this Contract.

    A service or supply is furnished at the direction of a Physician or Professional Other Provider if the listed service or supply is: (a) provided by a person employed by the directing Physician or Professional Other Provider; (b) provided at the usual place of business of the directing Physician or Professional Other Provider; and (c) billed to the patient by the directing Physician or Professional Other Provider.

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

    Medical-Surgical Expense shall include:

    a. Services of Physicians or Professional Other Providers.

    b. Services of a certified registered nurse-anesthetist.

c. Physical Medicine Services as described in Article IV, Section 1, Subsection m(2), of this Contract.

d. Diagnostic x-ray and laboratory procedures.

e. Radiation therapy.

f. Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

g. Rental of durable medical equipment required for therapeutic use unless We require purchase of such equipment. The term ***durable medical equipment*** shall *not* include:

(1) Equipment primarily designed for alleviation of pain or provision of patient comfort; or

(2) Home air-fluidized bed therapy.

Examples of *non-covered* equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment

h. Professional local ground ambulance service or air ambulance service as described in Article IV, Section 1, Subsection m(3), of this Contract.

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

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

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

l. Prosthetic Appliances, excluding all replacements of such devices other than those necessitated by growth to maturity of the Participant.

m. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

n. Home Infusion Therapy. Any item of Home Infusion Therapy covered under this subsection will not be eligible for benefits under any other provision of this Contract.

o. Services or supplies used by the Participant during an outpatient visit to a Hospital or a Therapeutic Center.

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

a. 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

b. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and

c. Not primarily for the convenience of the Participant, his Physician, his Hospital, or his Other Provider; and

d. The most economical supplies or levels of services that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

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

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

47. **Network** means a group of Physicians, specialists, Hospitals and other health care facilities who have executed a managed care agreement with Us for the provision of health care to Participants covered under this Contract.

48. **Network Benefits** means the benefits available under this Contract for services and supplies that are provided by a Network Provider.

49. **Network Physician** means a Physician or Professional Other Provider who has executed a managed care

agreement with Us for the provision of health care to Participants covered under this Contract.

50. **Network Provider** means a Hospital, Physician, or Other Provider that has executed a managed care agreement with Us for the provision of care to Participants covered under this Contract.

51. **Non-Participating Pharmacy** means a Pharmacy which has not entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

52. **Non-Preferred Brand Name Drug** means a brand name drug which does not appear on the Preferred Brand Name Drug List but has a therapeutic equivalent that is listed in the Preferred Drug List.

53. **Non-Preferred Brand Name Drug Copayment Amount** means the Copayment Amount applicable when a Non-Preferred Brand Name Drug is dispensed. This Copayment Amount is higher than the Generic Drug Copayment and Preferred Brand Name Drug Copayment Amount.

54. **Oral Surgery** means maxillofacial surgical procedures limited to:

    a. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;

    b. Incision and drainage of facial abscess;

    c. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and

    d. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded in Article V of this Contract.

55. **Organic Brain Disease** means the diagnosis or treatment of a mental disease, disorder or condition as defined by the *American Psychiatric Association in the Diagnostic and Statistical Manual III-R* or the *International Classification of Diseases, Ninth Revision* (ICD-9) Procedure Codes 290-294 and 310.

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

    a. **Facility Other Provider** — an institution or entity, only as listed:

        (1) Durable Medical Equipment Provider
        (2) Home Health Agency
        (3) Home Infusion Therapy Provider
        (4) Hospice
        (5) Imaging Center
        (6) Independent Laboratory
        (7) Prosthetic/Orthotics Provider
        (8) Renal Dialysis Center
        (9) Skilled Nursing Facility
        (10) Therapeutic Center

    b. **Professional Other Provider** — a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:

        (1) Advanced Practice Nurse
        (2) Doctor of Chiropractic
        (3) Doctor of Dentistry
        (4) Doctor of Optometry
        (5) Doctor of Podiatry
        (6) Doctor in Psychology
        (7) Licensed Acupuncturist
        (8) Licensed Audiologist
        (9) Licensed Hearing Instrument Fitter and Dispenser
        (10) Licensed Occupational Therapist
        (11) Licensed Physical Therapist
        (12) Licensed Speech-Language Pathologist
        (13) Physician Assistant

    Such terms as used herein, unless otherwise defined in this Contract, shall have the meaning assigned to them by the *Texas Insurance Code*. In states where there is a licensure requirement, such Other Providers must be licensed by the appropriate state administrative agency.

57. **Out-of-Network Benefit** means the benefits available under this Contract for services and supplies that are provided by an Out-of-Network Provider.

58. **Out-of-Network Provider** means a Hospital, Physician, or Other Provider, as defined in this Contract, that has not executed a managed care agreement with Us for the provision of health care to Participants covered under this Contract.

59. **Participant** means the Subscriber or a Dependent, as defined herein, for whom application has been made by the Subscriber and accepted by Us.

60. **Participating Pharmacy** means a Pharmacy which has entered into an agreement to provide prescription drug services to Participants under the Prescription Drug Program.

61. **Pharmacy** means:

    a. A state licensed establishment where the practice of pharmacy occurs that is physically separate and apart from any Provider's office, and

    b. Where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

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

63. **Physician** means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the *Texas Insurance Code*.

64. **Plan Service Area** means the geographical area that We designate which determines eligibility for Network Benefit as shown on the zip code listing attached to and made a part of this Contract.

65. **Preexisting Conditions** means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the two-year period immediately preceding the Effective Date of the Participant's coverage hereunder or a condition for which medical advice or treatment was recommended by a Physician or Professional Other Provider or received from a Physician or Professional Other Provider within the two-year period immediately preceding the Effective Date of the Participant's coverage hereunder.

66. **Preferred Brand Name Drug** means a brand name drug which appears on the Preferred Brand Name Drug List.

67. **Preferred Brand Name Drug Copayment Amount** means the Copayment Amount applicable when a Preferred Brand Name Drug is dispensed. This Copayment Amount is higher than the Generic Drug Copayment Amount.

68. **Preferred Brand Name Drug List** means a sample listing of the most commonly prescribed medications available in the Preferred Brand Name category. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other pharmacy and medical related organizations, describing clinical outcomes, drug efficacy; and side effect profiles.

69. **Prescription Order** means a written or verbal order from a Physician and/or Professional Other Provider to a Pharmacist for a drug or device to be dispensed. Orders written by a Physician and/or Professional Other Provider located outside the United States to be dispensed in the United States are not covered under this Contract.

70. **Proof of Loss** means written evidence of a claim including:

    a. The form on which the claim is made; and

    b. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and correct diagnosis code(s) and procedure code(s) for the services and items.

71. **Prosthetic Appliances** means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). *For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.*

72. **Prosthetic/Orthotics Provider** means a certified prosthetist that supplies both standard and customized prostheses and orthotic supplies.

73. **Provider** means a Hospital, Physician, Other Provider, or any other person, company, or institution furnishing to a Participant a service or supply listed as an Eligible Expense in this Contract.

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

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

    a. Is licensed in accordance with state law (where the state law provides for licensing of such facility); or

    b. Is Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

76. **Speech and Hearing Services** means the measurement, testing, evaluation, prediction, counseling, habilitation, rehabilitation, or instruction related to the development and disorders of speech, voice or language, or to hearing or disorders of hearing.

77. **Subscriber** means the person named on the Identification Card enclosed with this Contract.

78. **Therapeutic Center** means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is: (a) an ambulatory (day) surgery facility; or (b) a freestanding radiation therapy center.

79. **You, Your, Yourself** means the person named on the Identification Card enclosed with this Contract.

Article II — Effective Date of Dependent Coverage

1. **Newborn Child**

Coverage of Your natural child born after Your Effective Date will be in effect from the date of birth through the 31st day following the date of birth.

To continue coverage beyond this 31-day period, You must notify Us within 31 days of the birth and pay the required premium within the first 31 days following the date of birth. If You wait until after this 31-day period to add the child, coverage shall be contingent upon You making application for such coverage on a form approved by Us.

The application form and satisfactory evidence of insurability must be submitted to Us at Our Administrative Office. Subject to Our approval of the application, evidence of insurability, and payment of the required premium, coverage shall become effective on the first day of the Contract Month following the date We approve the application.

2. **Court Ordered Coverage for Dependents**

If You have coverage under this Contract and if You are required to provide coverage for a minor child as a result of a medical support order issued 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, You must make application for coverage on a form approved by Us and pay the required premium within that 31-day period. If We receive notification after the 31-day period, coverage shall be contingent upon the Subscriber's making application for such coverage on a form approved by Us. The application form and satisfactory evidence of insurability must be submitted to Us at Our Administrative Office. Subject to Our 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 Contract Month following the date We approve the application.

3. **Other Dependents**

    a. Coverage for a Dependent (other than a natural newborn child, an adopted child or a child involved in a suit for adoption, or a court ordered child) shall be contingent upon You making application for such coverage on a form approved by Us. The application form must be submitted to Us at Our Administrative Office. Subject to Our approval of the application and payment of the required premium, coverage for each Dependent listed on the initial application at the same time as the Subscriber, shall become effective on the Effective Date of this Contract.

    b. Coverage for a Dependent (other than a natural newborn child or a child involved in a suit for adoption, or a court ordered child) of a Subscriber already having coverage under this Contract shall be

contingent upon You making application for such coverage on a form approved by Us. The application form and satisfactory evidence of insurability must be submitted to Us at Our Administrative Office. Subject to Our approval of the application, evidence of insurability, and the required premium, coverage shall become effective on the first day of the Contract Month following the date We approve the application.

Article III — Payment of Benefits/Participant Provider Relationship

1. **Payment of Benefits**

   a. When benefits are payable, We may choose to pay You or the Provider with certain exceptions. Written contracts between Us and certain Providers may require payment directly to them. Payment to the Provider discharges Our responsibility to the Participant for any benefits available under this Contract.

   b. Except as provided above, the rights and benefits of this Contract shall not be assignable, either before or after services and supplies are provided. However, if a written assignment of benefits is made by a Participant to a Provider and the written assignment is delivered to Us with the claim for benefits, We will make any payment directly to the Provider.

   c. It is understood and agreed that the allowances described in Article IV for services and supplies furnished by a Provider whom We do not directly contract with: (1) are not intended to and do not fix their value of the services of the Provider; and (2) relate to or regulate their value; the Provider may make its regular charge. The allowances are merely to apply as credits.

   d. Any benefits payable to You shall, if unpaid at Your death, be paid to Your surviving spouse, as beneficiary; if there is no surviving spouse, then such benefits shall be paid to Your estate.

2. **Participant/Provider Relationship**

   The choice of a health care Provider should be made solely by You or Your Dependents. We are not liable for any act or omission by any health care provider. We do not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to You or Your Dependents.

Article IV — Benefits Provided

1. Subject to the conditions described below and the Medical Limitations and Exclusions in this Contract, when any Participant while covered hereunder incurs Eligible Expenses, benefits shall be determined as follows:

   a. **Introduction**

   We have established a network of Providers to serve Participants throughout Texas. By using Providers in the Network, You will maximize the benefits available to You under this Contract. You will receive a directory when You enroll listing Network Providers in Your Plan Service Area. To get a current directory or inquire about a Network Provider, call Our Customer Service Helpline.

   You have the freedom to use any health care Provider outside the Network and still receive benefits for covered services under this Contract. However, You will receive the lower level of benefits. See below for discussion of *Par*Plan Providers.

   b. **How the Medical Plan Works**

      (1) To receive Network Benefits under this portion of this Contract, care must be provided by a Network Provider. Refer to the Provider Directory to make Your selections. You are generally not required to submit claim forms when You use a Network Provider.

      If You choose a Network Provider, the Provider will bill Us — not You — for services provided. The Network Provider has agreed to accept as payment in full the least of:

      (a) The billed charges,

      (b) The Allowable Amount as determined by Us, or

      (c) Other contractually determined payment amounts,

and the Deductible, Copayment and Coinsurance Amounts You are responsible for paying. You are also responsible for limited or non-covered services, precertification, and any penalty required when precertification is not obtained.

(2) If Your Network Physician admits You to an out-of-network facility, Network Benefits will be available for the Network Physician's charges and Out-of-Network Benefits will be available for the facility charges.

(3) If You choose a Provider outside the Network, benefits will be provided at the Out-of-Network Benefits level, except as described under **Emergency Care**.

You may have to submit Your own claim forms for reimbursement of out-of-network expenses.

You will be responsible for billed charges above Our payment amount. Coinsurance Amounts, Deductibles, limited or non-covered services, precertification and any penalties for not precertifying care when required.

(4) If You choose a Physician outside the Network and he admits You to a facility participating in the Network, Out-of-Network Benefits will be available for the Physician charges and Network Benefits will be available for the facility charges.

(5) If You require services that are not available from a Network Provider, Network Benefits will be provided when You use Out-of-Network Providers.

c. **Medical Necessity**

All services and supplies for which benefits are available under this Contract must be Medically Necessary as determined by Us. Charges for services and supplies that We determine are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or apply to the Coinsurance Amounts.

d. ***ParPlan* Providers**

When You consult an Out-of-Network Physician or Professional Other Provider, You should inquire if he participates in the BCBSTX *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

- File all claims for You,
- Accept Our Allowable Amount determination as payment for Medically Necessary services, and
- Not bill You for services over the Allowable Amount determination.

You will be responsible for any applicable Deductibles and Coinsurance Amount, and services that are limited or not covered under this Contract.

If Your Physician or Professional Other Provider does not participate in the *ParPlan*, You will be responsible for filing all claims for services rendered and you may be billed for services above Our Allowable Amount determination.

e. **Precertification Requirements**

Precertification is required for all Hospital Admissions, *Extended Care Expense*, Home Infusion Therapy, and organ and tissue transplants.

Precertification establishes in advance the Medical Necessity of certain care and services covered under this Contract. It ensures that the precertified care and services as described below will not be denied on the basis of Medical Necessity. Precertification does not guarantee payment of benefits.

(1) **Hospital Admissions**

You are required to have Your admission precertified at least two working days prior to the actual admission unless it would delay Emergency Care. In an emergency, precertification should take place within two working days after the admission or as soon as reasonably possible.

When a Hospital Admission is precertified, a length-of-stay is assigned. This Contract is

required to provide a minimum length of stay in a Hospital for treatment of breast cancer of:

- 48 hours following a mastectomy; and
- 24 hours following a lymph node dissection.

If You require a longer stay than was first precertified, Your Provider may request an extension for additional inpatient days. If an admission extension is not precertified, benefits may be reduced or denied.

Precertification is also required if You transfer to another facility or to or from a specialty unit within the facility.

If an admission is not precertified, benefits may be reduced or denied if We determine that the admission is not Medically Necessary.

Failure to precertify will result in a penalty in the amount of $250 which will be deducted from any benefits which may be finally determined to be available for the Hospital Admission. This penalty amount cannot be used to satisfy Deductibles or to apply toward the Coinsurance Amounts. Additionally, We will review the Medical Necessity of Your claim.

(2) **Extended Care Expense and Home Infusion Therapy**

Precertification is required for Medically Necessary Skilled Nursing Facility services, Home Health Care, Hospice Care or Home Infusion Therapy.

Precertification for *Extended Care Expense* and Home Infusion Therapy must be obtained by having the agency or facility providing the services submit a treatment plan to Us on a Precertification Review Form. The Precertification Review Form must be completed:

- Before the start of Extended Care Expense or Home Infusion Therapy;
- For periodic recertification of Extended Care Expense or Home Infusion Therapy, and
- When the treatment plan is altered.

If *Extended Care Expense* or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the precertification telephone number on the back of Your Identification Card.

We will review the information submitted prior to the start of *Extended Care Expense* or Home Infusion Therapy. A letter will be sent to You and the agency or facility confirming precertification or denying benefits. If *Extended Care Expense* or Home Infusion Therapy is scheduled to occur within 72 hours, We will notify the agency or facility by telephone. **No benefits will be available for charges incurred when the corresponding treatment plan has been previously denied based on the information submitted.**

Failure to precertify will result in a penalty in the amount of 50% not to exceed $500 which will be deducted from any benefits which may be finally determined to be available for *Extended Care Expense* or Home Infusion Therapy.

(3) **Organ and Tissue Transplants**

Precertification is required for any organ or tissue transplant. Precertification of an organ or tissue transplant is the process by which the Medical Necessity of the transplant and the length of stay of the admission is approved or denied. Precertification does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the precertified length of stay will not be denied on the basis of Medical Necessity.

At the time of precertification, We will assign a length-of-stay for the admission if We determine that the admission is Medically Necessary. Upon request, the length-of-stay may be extended if We determine that an extension is Medically Necessary.

f. **Copayment Amounts and Deductibles**

The benefits of this Contract will be available after satisfaction of the Copayment Amounts, if applicable, and any Deductibles for Network Benefits and Out-of-Network Benefits.

(1) **Copayment Amounts**

(a) The Copayment Amounts indicated on Your application for this Contract will be required for most Physicians office visits except for services provided by an Independent Lab or radiologist requested by the Physician. If the services provided require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. The Copayment Amount is required even if the Coinsurance Amounts have been met.

The following services are not payable under this Copayment Amount provision, but instead are considered *Medical-Surgical Expense*, subject to the Deductible and Coinsurance:

- Surgery performed in the Physician's office;
- Physical therapy billed separately from an office visit;
- Occupational modalities in conjunction with physical therapy;
- Allergy injections billed separately from an office visit;
- Therapeutic injections; or
- Any services requiring Precertification.

(b) A $75 Copayment Amount is required for each emergency/treatment room visit only. Eligible Expenses for other covered charges provided at the time of the emergency/treatment visit (e.g. facility and Physician charges and lab or X-ray) will be subject to the Deductible and Coinsurance Amounts. The Copayment Amount will be waived if the Participant is admitted to the Hospital immediately following the visit.

(c) The Physician office visit Copayment Amount does not apply an Out-of-Network Physician or Professional Other Provider renders the services.

(2) **Deductibles**

(a) The Deductible amounts indicated in Your application for this Contract will be subtracted once during each Calendar Year from the Participant's total combined *Inpatient Hospital Expense* and *Medical-Surgical Expense* incurred for that Calendar Year.

(b) Any Eligible Expenses applied toward satisfying the Out-of-Network Deductible will apply toward satisfying the Network Deductible.

(c) Any Eligible Expenses applied toward satisfying the Network Deductible will not apply towards the Out-of-Network Deductible.

(d) When the total amount of the Deductible incurred in a Calendar Year by Participants under Your coverage equals three times the individual Deductible amount indicated in the application for this Contract, all such Participants will have satisfied their Deductible for the remainder of that Calendar Year. No Participant will be allowed to contribute more than the individual Deductible amounts to the family Deductible amount.

g. **Coinsurance Amounts**

(1) When a Participant's Coinsurance Amounts during a Calendar Year equal the individual amount indicated on Your application for coverage under this Contract for Network or Out-of-Network Benefits, the benefit percentages automatically become 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant during the remainder of that Calendar Year.

(2) When the total amount of the Coinsurance Amounts incurred in a Calendar Year by Participants under Your coverage equals the family Coinsurance Amounts indicated on Your application for coverage under this Contract, all such Participants will have satisfied their Coinsurance Amount for the remainder of that Calendar Year. No

Participant will be allowed to contribute more than the individual Coinsurance Amount to the family Coinsurance Amount.

(3) Any Eligible Expenses applied toward satisfying the Out-of-Network Coinsurance Amount will apply toward satisfaction of the Network Coinsurance Amount.

(4) Any Eligible Expenses applied toward satisfying the Network Coinsurance Amount will not apply toward satisfaction of the Out-of-Network Coinsurance Amount.

(5) Most of Your payment obligations are considered as Coinsurance Amounts and are applied to the Coinsurance Amount. Such Eligible Expenses do **not** include:

(a) Services, supplies, and charges limited or excluded by this Contract; or

(b) Expenses not covered because a benefit maximum has been reached; or

(c) Deductibles for Network Benefits and Out-of-Network Benefits; or

(d) The Copayment Amounts for Network Physician office visits or emergency room visits; or

(e) Any Copayment Amounts under the Prescription Drug Program; or

(f) Penalties for not precertifying *Inpatient Hospital Expense*, *Extended Care Expense*, or Home Infusion Therapy.

(6) Copayment Amounts will continue to be required after the benefit percentage becomes 100%.

h. **Maximum Benefits**

(1) The total amount of benefits available during the lifetime of any one Participant under this Contract shall not exceed $2,000,000.

(2) The maximum lifetime benefit amount includes all payments made under any benefit provision of this Contract for Network Benefits and Out-of-Network Benefits.

(3) The maximum lifetime benefit amount is reduced in the amount of any benefits provided under the Subscriber's Select 2000℠ Plan Contract, the PPO Select℠ Plan Contract, and PPO Select Advantage℠ Plan Contract held with Us immediately prior to a Participant's effective date under this Contract.

(4) All benefit payments made by Us for Physical Medicine Services, ground or air ambulance services, *Extended Care Expense*, preventive care services and prescription drugs, whether under the Network Benefits level or Out-of-Network Benefits level, will apply toward the Calendar Year benefit maximums under both levels of benefits.

i. **Benefits for Inpatient Hospital Expense**

If *Inpatient Hospital Expense* is incurred during each Hospital Admission in excess of the applicable Deductible as indicated on your application for coverage under this Contract, benefits will be provided at 85% for services received in a Network Hospital or 75% for services received in an Out-of-Network Hospital.

j. **Benefits for Medical-Surgical Expense**

Copayment Amounts must be paid to Your Network Physician or other Network Provider at the time You receive services.

If *Medical-Surgical Expense* is incurred by a Participant in excess of the applicable Deductible and Copayment Amount as indicated on Your application for coverage under this Contract, benefits will be provided at 85% of the Allowable Amount for Network Benefits and 75% of the Allowable Amount for Out-of-Network Benefits. The remaining unpaid *Medical-Surgical Expense* in excess of the Copayment Amount and Deductible will be applied to the Coinsurance Amounts.

k. **Benefits for Extended Care Expense**

When *Extended Care Expense* is precertified, as previously explained in Article IV, Section 1e(2), of this Contract, We will provide benefits at: (a) 100% for Network Benefits, and (b) 75% for Out-of-Network Benefits, up to the amount of the combined benefit maximums shown below for each category of *Extended Care Expense*. The Deductible will not apply to *Extended Care Expense*.

Any Home Health Care or home Hospice Care charges for drugs (including antibiotic therapy) and

laboratory services will not be *Extended Care Expense* but will be considered *Medical-Surgical Expense.*

Services and supplies for *Extended Care Expense*:

(1) For Skilled Nursing Facility — *Calendar Year maximum benefit — $5,000 per Participant*

(a) All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);

(b) Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;

(c) Physical, occupational, speech, and respiratory therapy services by licensed therapists.

(2) For Home Health Care — *Calendar Year maximum benefit — $5,000 per Participant*

(a) Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);

(b) Part-time or intermittent home health aide services which consist primarily of caring for the patient;

(c) Physical, occupational, speech, and respiratory therapy services by licensed therapists;

(d) Supplies and equipment routinely provided by the Home Health Agency.

(e) Benefits will *not* be provided for Home Health Care for the following:

i) Food or home delivered meals;

ii) Social case work or homemaker services;

iii) Services provided primarily for Custodial Care;

iv) Transportation services;

v) Home Infusion Therapy;

vi) Durable medical equipment.

(3) Hospice Care — *Lifetime maximum benefit — $10,000 for each Participant*

(a) For Home Hospice Care:

i) Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);

ii) Part-time or intermittent home health aide services which consist primarily of caring for the patient;

iii) Physical, speech, and respiratory therapy services by licensed therapists;

iv) Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

(b) For Facility Hospice Care:

(1) All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);

(2) Room and board and all routine services, supplies, and equipment provided by the Hospice facility;

(3) Physical, speech, and respiratory therapy services by licensed therapists.

l. **Case Management**

Case management identifies Participants with specific chronic or acute illnesses or injuries that have lengthy and complicated treatment plans.

Under certain circumstances, We may offer benefits for expenses, which are not otherwise Eligible Expenses under this Contract. We, at Our sole discretion, may offer such benefits if:

(1) The Participant, his family, and the Physician agree; and

(2) The benefits are cost effective; and

(3) We anticipate future expenditures for Eligible Expenses, which may be reduced by such benefits.

Any decision We make to provide such benefits shall be made on a case-by-case basis. Our case coordinator will initiate case management in appropriate situations. Our determination to provide alternative benefits in one instance shall neither commit Us to provide the same or similar alternative benefits for the same Participant or any other Participant nor causes Us to waive Our right to strictly apply the express provisions of this Contract in the future.

m. **Special Benefit Provisions**

Benefits available under this section are generally determined on the same basis as for other *Inpatient Hospital Expense, Medical-Surgical Expense,* and *Extended Care Expense,* except to the extent described in the following subsections.

(1) **Benefits for Treatment of Complications of Pregnancy**

(a) Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be the same as for treatment of sickness.

(b) Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are not covered under this Contract.

(2) **Benefits for Physical Medical Services**

If a Participant incurs *Medical-Surgical Expense* for Physical Medicine Services, benefits will be provided on the same basis as any other sickness for Network Benefits and Out-of-Network Benefits up to a maximum benefit amount of $1,000 per Calendar Year for each Participant. The Deductible will be applied.

(3) **Benefits for Ground and Air Ambulance Services**

If *Medical-Surgical Expense* is incurred for professional local ground ambulance or air ambulance services to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition, benefits will be provided at the Network Benefits level, up to a maximum benefit amount of $1,500 per Calendar Year for each Participant. The Deductible will be applied.

(4) **Benefits for Mammography Screening**

If a female Participant 35 years of age or older incurs *Medical-Surgical Expense* for a routine screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined as described under Preventive Care, except that if the maximum benefit amount has been reached under that benefit:

- Such Participant shall be entitled to benefits for one routine mammography screening each Calendar Year; and
- Benefits will be provided as described in the subsection entitled **Benefits for Medical-Surgical Expense**. A Copayment Amount will be required for Network Benefits for Physician office visits. The Calendar Year Deductible will apply to Out-of-Network Benefits.

(5) **Benefits for Certain Tests for Detection of Prostate Cancer**

If a male Participant incurs *Medical-Surgical Expense* for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be determined as described under Preventive Care, except that if the maximum benefit amount has been reached under that provision:

- Such Participant shall be entitled to benefits for a:
  - Physical examination for the detection of prostate cancer; and
  - Prostate-specific antigen test used for the detection of prostate cancer for each male under this Contract who is at least:
    a) 50 years of age and asymptomatic; or

b) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor, and

- Benefits will be provided as described in the subsection entitled **Benefits for Medical-Surgical Expense**. The Copayment Amount will be required for Network Benefit for Physician office visits. The Calendar Year Deductible will apply to Out-of-Network Benefits.

(6) **Benefits for Cosmetic, Reconstructive, or Plastic Surgery**

Benefits for Cosmetic, Reconstructive or Plastic Surgery will be the same as for treatment of any other sickness as described in this Contract for the following services only:

(a) Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant while covered under this Contract; or

(b) Treatment provided for reconstructive surgery following cancer surgery while the Participant is covered under this Contract; or

(c) Surgery performed on a newborn child for the treatment or correction of a congenital defect; or

(d) Surgery performed on a Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast.

(e) Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

(f) Reconstructive surgery performed on a Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

(7) **Benefits for Dental Services**

(a) If a Participant incurs Eligible Expenses for the dental services listed below, benefits will be the same as for treatment of any other sickness as described in this Contract. Benefits will be provided only for:

i) Oral Surgery as defined in Article I of this Contract; or

ii) Services provided to a Dependent child which are necessary for treatment or correction of a congenital defect; or

iii) The correction of damage caused solely by external, violent Accidental Injury to healthy, unrestored natural teeth and supporting tissues occurring while the Participant was covered under this Contract and limited to such services and supplies provided:

a) For 24 months from the date of accident; or
b) To the termination date of this Contract,

Whichever occurs first; except that an injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

(b) Except as excluded in Article V, Section 1, of this Contract, for any other dental services for which a Participant incurs *Inpatient Hospital Expense* for a Medically Necessary Hospital Admission, benefits will be determined as described in the

subsection entitled **Benefits for Inpatient Hospital Expense.**

(8) **Benefits for Emergency Care**

(a) Benefits for the following Emergency Care services shall be provided at the Network Benefits level until the patient can reasonably be expected to transfer to a Network Hospital.

(1) Any medical screening examination or other evaluation required by state or federal law to be provided in the emergency department of a Hospital which is necessary to determine whether an emergency medical condition exists;

(2) Necessary Emergency Care services including the treatment and stabilization of an emergency medical condition; and

(3) Services originating in a Hospital emergency department following treatment or stabilization of an emergency medical condition.

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for benefits at the Network Benefits level subject to the Deductible and Coinsurance Amount.

(b) After 48 hours, Network Benefits will be available only if You use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency, and if You can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available.

(c) A $75 Copayment Amount will be required for each outpatient Hospital emergency room visit as indicated on Your application for coverage under this Contract. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived.

(9) **Benefits for Preventive Care**

Medical-Surgical Expense incurred for the following preventive care services will be available under this Contract up to a $300 combined Calendar Year benefit maximum per Participant for Network and Out-of-Network Benefits:

(a) Routine physical examinations,
(b) Well-child care,
(c) Hemoccult tests,
(d) Pap smears,
(e) Immunizations for Participants 8 years of age and over,
(f) Routine lab and X-ray, and
(g) Vision and hearing examinations.

Network Benefits will be determined at 100% of the Allowable Amount for Physician office visits and same day diagnostic lab and x-rays. The Copayment Amount will be required.

Out-of-Network Benefits will be determined at 75% of the Allowable Amount for Physician office visits and diagnostic lab and x-rays. The Calendar Year Deductible will be applied.

Benefits are not available for *Inpatient Hospital Expense* or *Medical-Surgical Expense* for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

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

(10) **Required Benefits for Childhood Immunizations**

Benefits for *Medical-Surgical Expense* incurred by a Dependent child through age 7 for childhood immunizations will be determined at 100% of the Allowable Amount for Network Benefits and Out-of-Network Benefits. The Deductible, Coinsurance Amount, and Copayment Amounts, if any, will not be applicable.

Benefits are available for:

(a) Diphtheria,
(b) Hemophilus influenza type b,
(c) Hepatitis B,

(d) Measles,
(e) Mumps,
(f) Pertussis,
(g) Polio,
(h) Rubella,
(i) Tetanus,
(j) Varicella, and
(k) Any other immunization that is required by law for the child.

Allergy injections are not considered immunizations under this benefit provision.

(11) **Required Benefits for Screening Test for Hearing Impairment**

Benefits are available for *Medical-Surgical Expense* incurred by a Dependent child:

(a) For a screening test for hearing loss from birth through the date the child is 30 days old; and

(b) Necessary diagnostic follow-up care related to the screening test from the date of birth through the date that the child is 24 months old.

The Deductible will not apply. However, benefits will be subject to all other contractual provisions.

(12) **Benefits for Treatment of Diabetes**

Benefits are provided for those Medically Necessary items of *Medical-Surgical Expense* associated with the treatment of diabetes. Such items, when obtained for a ***qualified participant***, shall include but not be limited to the following:

(a) Diabetic Equipment

(1) Blood glucose monitors (including monitors for the blind);

(2) Insulin pumps (both external and implantable) and associated appurtenances, which include:

- Batteries,
- Skin preparation items,
- Adhesive supplies,
- Infusion sets,
- Insulin cartridges,
- Durable and disposable devices to assist in the injection of insulin, and
- Other required disposable supplies;

(3) Insulin infusion devices; and

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

(b) Diabetic Supplies

(1) Test strips for blood glucose monitors,

(2) Visual reading and urine test strips and tablets for glucose, ketones and protein,

(3) Lancets and lancet devices,

(4) Insulin and insulin analogs preparations,

(5) Injection aids, including devices used to assist with insulin injection and needle-less systems,

(6) Biohazard disposable containers,

(7) Insulin syringes,

(8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and

(9) Glucagon emergency kits.

However, insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents will be covered under the Prescription Drug Program.

(c) Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

(d) New and improved treatment and monitoring equipment or supplies which are approved by the U. S. Food and Drug Administration if it is determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider.

(e) Medical-*Surgical Expense* provided for the nutritional, educational and psychosocial treatment of the diabetic patient. Such management is limited to the following services when rendered by or under the direction of a Physician:

Initial and follow-up instruction concerning:

(1) The physical cause and process of diabetes;

(2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;

(3) Prevention and treatment of special health problems for the diabetic patient;

(4) Adjustment to lifestyle modifications; and

(5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

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

(13) **Benefits for Organ and Tissue Transplants**

(a) Subject to the conditions described below, including the organ and tissue transplant maximum, Network Benefits and Out-of-Network Benefits for covered services and supplies provided to a Participant (donor and/or recipient) by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if:

i) The transplant procedure is not Experimental/Investigational in nature;

ii) Donated human organs or tissue are used;

iii) The recipient is a Participant under this Contract. Benefits are also available to a live donor to the extent that benefits remain under the recipient's contract after benefits for the recipient's expenses have been provided;

iv) The transplant procedure is precertified as provided in Section 1, Subsection e(3), of this Article IV;

v) The Participant meets all of the criteria established by Us in Our written medical policy guidelines; and

vi) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies ***related to*** an organ or tissue transplant include, but are not limited to, x-rays, laboratory, chemotherapy, radiation therapy, prescription drugs, and complications arising from such transplant.

(b) Benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is for the:

i) Liver;
ii) Heart;
iii) Heart—Lung (heart and one lung or heart and two lungs);
iv) Kidney;
v) Cornea;
vi) Lung;
vii) Bone Marrow.

(c) Covered services and supplies include services and supplies provided:

i) For the evaluation of organs or tissues including, but not limited to, the determination of tissue matches;

ii) For the removal of organs or tissues from deceased donors; and

iii) For the transportation and storage of donated organs or tissues.

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

i) Living and/or travel expenses of the live donor or recipient;

ii) Donor search and acceptability testing of potential living donors;

iii) Expenses related to maintenance of life for purposes of organ or tissue donation; and

iv) Purchase of the organ or tissue.

(e) No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such procedure) which We consider to be Experimental/Investigational.

(f) The total amount of benefits for organ and tissue transplants available to any one Participant under this Contract shall not exceed a $300,000 maximum. This maximum shall include benefits provided for prescription drugs used while in the Hospital. Benefits for drugs used on an outpatient basis will be provided under the Prescription Drug Program and will be subject to the Calendar Year maximum benefit amount specified in Article IV, Section 2b(3), of this Contract.

2. Prescription Drug Program

a. Your Identification Card

The Identification Card You received is the key to Your use of the Prescription Drug Program. It tells Participating Pharmacies that You are entitled to prescription drug benefits under the Prescription Drug Program. Participating Pharmacies are not permitted to file claims with the Carrier unless You present the Identification Card with Your Prescription Order.

Note: If You do not have Your Identification Card, You must pay the Participating Pharmacy directly for Your prescription charges. You must file a claim with the Carrier. You will then be reimbursed for Your payments less the appropriate Copayment Amount and any applicable pricing difference.

Any time a change in Your family takes place it may be necessary for a new Identification Card to be issued to You. Upon receipt of the change information, a new Identification Card will be issued to You.

Unauthorized, Fraudulent, Improper or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper or abusive use of Identification Cards issued to you and your covered family members will include, but not be limited to:

   a. Use of the Identification Card prior to your Effective Date;

   b. Use of the Identification Card after your date of termination of coverage under this Contract;

   c. Obtaining prescription drugs or other benefits for persons not covered under this Contract;

   d. Obtaining prescription drugs or other benefits which are not covered under this Contract;

   e. Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under this Contract;

   f. Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;

   g. Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of this Contract;

   h. Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;

   i. Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.

2. The unauthorized, fraudulent, improper or abusive use of Identification Cards by any Participant can result in, but is not limited to, the following sanctions being applied to all Participants covered under your coverage:

   a. Denial of benefits;

b. Cancellation of coverage under this Contract of all Participants under your coverage;

c. Limitation on the use of Identification Card to one designated Participating Pharmacy of your choice;

d. Recoupment from you or any of your covered family members of any benefit payments made;

e. Pre-approval of drug purchases for all Participants covered under your coverage;

f. Notice to proper authorities of potential violations of law or professional ethics.

b. How It Works

When You need a Prescription Order filled, You can elect to go to a Participating or Non-Participating Pharmacy. It is usually financially beneficial to You to utilize Participating Pharmacies.

(1) ***Participating Pharmacy***

When You go to a Participating Pharmacy:

- present your Identification Card to the pharmacist along with Your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log, and
- pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference, if any.

Participating Pharmacies have agreed not to bill You for any covered prescription drug expenses in excess of the Copayment Amount plus any pricing difference.

If You are unsure whether a pharmacy is a Participating Pharmacy, You may contact the Customer Service Helpline. You must present Your Identification Card to Your Participating Pharmacy in order to receive full Contract benefits.

(2) ***Non-Participating Pharmacy***

If You have a Prescription Order filled at a Non-Participating Pharmacy, You must pay the Pharmacy the full amount of its bill and submit to the Carrier a claim form and itemized receipt verifying that the prescription was filled. We will pay benefits equal to 80% of the billed charge (but not more than 80% of the Average Wholesale Price, plus a dispensing fee), less the appropriate Copayment Amount and any applicable pricing differences.

(3) ***Maximum Prescription Drug Benefit***

The maximum amount of benefits available under the Program is $1,500 per Calendar Year for each Participant regardless of whether or not benefits are received at a Participating Pharmacy or Non-Participating Pharmacy.

(4) ***Copayment Amounts***

There are three Copayment Amounts shown on Your application for coverage for retail pharmacy. The amount You pay depends on the type of drug dispensed. If the drug dispensed is a:

a. Generic Drug - You pay the generic drug Copayment Amount,

b. Preferred Brand Name Drug - You pay the Preferred Brand Name Drug Copayment Amount and any pricing difference described below, if applicable,

c. Non-Preferred Brand Name Drug - You pay the Non-Preferred Brand Name Drug Copayment Amount.

(5) ***Preferred Brand Name Drug List***

A Preferred Brand Name Drug List is a sample listing of the most commonly prescribed medications available in the Preferred Brand Name Drug category. This list does not include all of the Preferred Brand Name Drugs. If a medication is not on the Preferred Brand Name Drug List, You may call the Customer Service Helpline to find out

which drugs are on the List and to determine Your benefit level.

This List will be updated from time to time to add new Preferred Brand Name Drugs. A new Preferred Brand Name Drug List will be provided to each Subscriber at least annually.

(6) ***How Copayment Amounts Apply***

When Your Physician has marked the Prescription Order "Dispense As Written" (DAW), the pharmacist may *only* dispense the brand name drug and You pay the appropriate Brand Name Copayment Amount.

If the Physician has not stipulated DAW, You may still choose to buy the brand name drug instead of the Generic Drug. If the brand name drug dispensed **is** on the Preferred Brand Name Drug List, You will pay the Preferred Brand Name Drug Copayment Amount **plus** the difference between the Generic Drug and the Preferred Brand Name Drug.

If the brand name drug is a Non-Preferred Brand Name Drug, You pay the Non-Preferred Brand Name Drug Copayment Amount.

(7) ***Generic Drugs***

The Program provides an incentive for using Generic Drugs. You are encouraged to take advantage of this incentive when Your prescribing Provider and pharmacist feel it is safe to do so and where state or federal laws permit. Generic Drugs offer Participants the lowest available Copayment Amount.

(8) ***Amount of Your Payment***

The amount of Your payment under the Program depends on whether:

(a) The Prescription Order is filled at a Participating Pharmacy; and

(b) A Generic Drug or brand name drug is dispensed.

c. Limitations on Quantities Dispensed

This Contract will pay for the dispensing of up to a 90-day supply of a Covered Drug on each occasion when you have a Prescription Order filled or refilled. A Copayment Amount applies to each 30-day quantity of drugs dispensed. This means when you receive a 90-day supply of drugs, you will pay ***three*** Copayment Amounts and any pricing differences.

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

Article V — Limitations and Exclusions

1. ***The benefits as described in Article IV, Section 1, of this Contract are not available for***:

   a. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction; or any Experimental/Investigational services and supplies

   b. Any services or supplies provided to any Participant for Maternity Care.

   c. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by Us.

   d. Any services or supplies for which benefits are, or could upon proper claims 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, including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or any laws, regulations or established procedures of any county or municipality, except as provided in Article VIII, Section 8. This Subsection 1d shall not be applicable to any legislation which specifies that the benefits of this Contract shall be deducted from the benefits available under such legislation.

e. Any charges for services and supplies provided which require Our approval when approval is not given.

f. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage (except treatment of mental illness or mental retardation by a tax supported institution).

g. Any services or supplies provided by a person who is related to the Participant by blood or marriage.

h. Any services or supplies provided for injuries sustained: (1) as a result of war, declared or undeclared, or any act of war; or (2) while on active or reserve duty in the armed forces of any country or international authority.

i. Any charges as a result of suicide or attempted suicide, or intentionally self-inflicted injury, while sane or insane.

j. Any charges: (1) resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or (2) for completion of any insurance forms; or (3) for acquisition of medical records.

k. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Participant's physical condition or the quality of medical care provided.

l. Any services or supplies provided during the course of a Hospital Admission or an admission in a Facility Other Provider which commences before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage, **except** as may be provided in Article VI, Section 1, Subsection f, of this Contract.

m. Any services or supplies provided for Dietary and Nutritional Services, except for an inpatient nutritional assessment program provided in and by a Hospital and approved by Us; any services or supplies provided by a Licensed Dietitian.

n. Any services or supplies for Custodial Care.

o. Any services or supplies provided in connection with a routine physical examination (including a routine Pap smear), diagnostic screening, or immunizations. This exclusion does not apply to the following **except** as provided for in the Special Benefit Provisions section in Article IV, of this Contract:

1. Mammography Screening,
2. Preventive Care over and above the Calendar Year benefit maximum,
3. Childhood Immunizations,
4. Certain Tests for the Detection of Prostate Cancer, or
5. Screening Tests for Hearing Impairment.

p. Any services or supplies (**except** for Medically Necessary diagnostic and surgical procedures) for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

q. Any services or supplies provided for orthognathic surgery after the Participant's 19th birthday. Orthognathic surgery includes, but is not limited to, correction of congenital, developmental or acquired maxillofacial skeletal deformities of the mandible and maxilla.

r. Any items of *Medical-Surgical Expense* incurred for dental care and treatments, dental surgery, or dental appliances, **except** as may be provided in Article IV, Section 1, of this Contract.

s. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, **except** as may be provided for in Article IV, Section 1, of this Contract.

t. Any services or supplies provided for:

(1) Treatment of myopia and other errors of refraction, including refractive surgery; or

(2) Orthoptics or visual training; or

(3) Eyeglasses, contact lenses or hearing aids, provided that intraocular lenses and cochlear implant devices shall be specific exceptions to this exclusion; or

(4) Examinations for the prescription or fitting of eyeglasses, contact lenses or hearing aids, **except** as may be provided for in the Special Benefit Provisions section in Article IV of this Contract.

u. Any services or supplies for mental and nervous disorders, **except** for Organic Brain Disease as defined in Article I of this Contract.

v. Any services or supplies provided by a Licensed Hearing Instrument Fitter and Dispenser.

w. Any Medical Social Services (**except** as may be provided as *Extended Care Expense*); any outpatient family counseling and/or therapy, bereavement counseling (**except** as provided as Hospice Care), vocational counseling, or Marriage and Family Therapy and/or counseling; any services or supplies provided by a Licensed Master Social Worker-Advanced Clinical Practitioner, a Licensed Professional Counselor, or a Marriage and Family Therapist.

x. Any services or supplies provided for treatment of adolescent behavior disorders, including conduct disorders and oppositional disorders.

y. Any services or supplies provided for treatment of Chemical Dependency unless an acute life-threatening condition occurs, in which case benefits for Eligible Expenses incurred in a Hospital during the acute life-threatening stage only will be provided on the same basis as for any other sickness; any services or supplies provided by a Licensed Chemical Dependency Counselor or a Licensed Psychological Associate.

z. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function.

aa. Travel, whether or not recommended by a Physician or Professional Other Provider, **except** for local ground ambulance service or air ambulance service otherwise covered hereunder.

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

cc. Any services or supplies provided primarily for:

(1) Environmental Sensitivity; or

(2) Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or

(3) Inpatient allergy testing or treatment.

dd. Any services or supplies provided as, or in conjunction with, chelation therapy, **except** for treatment of acute metal poisoning.

ee. Any services or supplies provided for, in preparation for, or in conjunction with:

(1) Sterilization reversal (male or female);

(2) Transsexual surgery;

(3) Sexual dysfunction;

(4) In vitro fertilization services; and

(5) Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct-intraperitoneal insemination, trans-uterine tubal insemination, gamete intrafallopian transfer, pronuclear oocyte stage transfer, zygote intrafallopian transfer, and tubal embryo transfer.

ff. Any services or supplies for routine foot care, such as:

(1) The cutting or removal of corns or callouses, the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory or bedfast patients; and

(2) Any services performed in the absence of localized illness, injury, or symptoms involving the foot; and

(3) Any treatment of a fungal (mycotic) infection of the toenail in the absence of:

(a) Clinical evidence of mycosis of the toenail;

(b) Compelling medical evidence documenting that the patient either:

i) Has a marked limitation of ambulation requiring active treatment of the foot; or

ii) In the case of a non-ambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment; and

iii) Excision of a nail without using an injectable or general anesthetic.

gg. Any drugs and medicines **except** as may be provided under the Prescription Drug Program that are:

(1) Dispensed by a Pharmacy and received by the Participant while covered under this Contract;

(2) Dispensed in a Provider's office or during confinement in a Hospital or other acute care institution of facility and received by the Participant for use on an outpatient basis,

(3) Over-the-counter drugs and medicines or for drugs for which no charge is made,

(4) Prescription antiseptic or fluoride mouth-washes, mouth rinses, or topical oral solutions or preparations,

(5) Retin-A or pharmacological similar topical drugs, or

(6) Smoking cessation prescription drug products requiring a Prescription Order.

hh. Any Speech and Hearing Services. This exclusion does not apply to the following **except** as provided for in the Special Benefit Provisions section in Article IV of this Contract:

(1) *Extended Care Expense,*

(2) Preventive Care; and

(3) Screening Tests for Hearing Impairment.

ii. Any services or supplies for Eligible Expenses incurred for a Preexisting Condition during a period of 24 months beginning with the Participant's Effective Date under this Contract. This Preexisting Condition exclusion shall not apply to a Participant:

(1) Who was continuously covered for an aggregate period of 18 months under Creditable Coverage if the previous coverage was in effect up to a date not more than 63 days before the Effective Date of the Participant's coverage under this Contract, excluding any waiting periods; and

(2) Whose most recent Creditable Coverage was under a group health plan, a governmental plan, or a church plan.

If a Participant's most recent prior Creditable Coverage was under a group plan, a governmental plan, or a church plan, but the Participant does not have aggregate Creditable Coverage totaling 18 months, We will credit the time the Participant was previously covered under Creditable Coverage if the previous coverage was in effect at any time during the 18 months preceding: (1) the first day coverage is effective under this Contract if there is not a waiting period, or (2) the day the applicant files a substantially complete application for coverage if there is a waiting period.

jj. Any services or supplies for reduction mammoplasty.

kk. Any services or supplies provided for the following treatment modalities: (1) acupuncture; (2) videofluoroscopy; (3) intersegmental traction; (4) surface EMGs; (5) manipulation under anesthesia; and (6) muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

ll. Orthodontic or other dental appliances; splints or bandages provided by a Physician in a non-hospital setting or purchased "over-the-counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts. This exclusion does not apply to podiatric appliances as described in Article IV, Section, 1m(12), of this Contract.

mm. Any services or supplies provided for or in conjunction with a condition which has been specifically excluded for a Participant as indicated in the application which is attached to and made a part of this Contract.

nn. Any services or supplies not specifically defined as an Eligible Expense under Article IV, Section 1 of this Contract.

2. The benefits as described in Article IV, Section 2, of this Contract are not available for:

a. Drugs which do not by law require a Prescription Order from a Provider (**except** injectable insulin); and drugs or covered devices for which no valid Prescription Order is obtained.

b. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections.

c. Administration or injection of any drugs.

d. Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).

e. Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

f. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this Section (f) shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

g. Any services provided or items furnished for which the Pharmacy normally does not charge.

h. Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Copayment Amount provided under this Contract.

i. Contraceptive devices, contraceptive materials, infertility medication, and fertility medication (**except** oral contraceptive medications which are Legend Drugs).

j. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

k. Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.

l. Covered Drugs dispensed in quantities in excess of the amounts stipulated in Article IV, Section 2c, of this Contract, or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

m. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA).

n. 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.

o. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.

p. Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.

q. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.

r. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under this Contract, or for which benefits have been exhausted.

s. Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in

the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

t. Any smoking cessation products requiring a Prescription Order.

u. Compounded drugs that do not meet the definition of Compound Drugs as defined in Article I of this Contract.

Article VI — Termination of Coverage

1. The coverage of the Subscriber and all covered Dependents under this Contract will terminate on the earliest of the following dates:

   a. On the last day of the last period for which the premium for this Contract has been paid to Us, subject to the grace period provided in Article VII, Section 3; or

   b. On the last day of any Contract Month upon written request for termination of this Contract made by the Subscriber and received by Us prior thereto; or

   c. On the date of death of the Subscriber; or

   d. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or

   e. On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area for which We are authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor; or

   f. On the date following 90 days advance notice by Us to the Subscriber, but only if We are terminating all other Form No. PPO-SELBLUE-ADV Plan Contracts; provided that We offer any hospital, medical, or surgical insurance coverage on a guaranteed issue basis to all applicants at the time of discontinuance of this Contract.

   g. In the event this Contract is terminated in accordance with the provisions of Subsection g, above, a Participant does not elect to purchase another individual hospital, medical or surgical insurance policy, coverage for any continuous illness or injury of a Participant which commenced while this Contract was in force shall, at termination, continue during the continuous Total Disability of the Participant and shall be limited to:

      (1) The duration of the policy benefit period; or

      (2) Payment of maximum benefits under this Contract; or

      (3) A period not less than 90 days.

      Total Disability, for purposes of this Subsection g, means the complete inability of a Participant as a result of injury or sickness to perform the usual tasks of his occupation, provided such Participant is not otherwise gainfully employed for wage or profit and is under the regular care of a Physician or Professional Other Provider.

   h. We may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if We:

      (1) Notify the Texas Department of Insurance Commissioner not later than 180 days prior to the date coverage under the first individual hospital, medical or surgical health benefit plan terminates;

      (2) Notify each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and

      (3) Act uniformly without regard to any Health-Status Related Factor of covered individuals or Dependents of covered individuals who may become eligible for coverage.

2. In addition to the provisions of Section 1, above, the coverage of any Dependent under this Contract shall terminate on the earliest of the following dates:

   a. At the end of the Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section 17, of this Contract, provided that:

      (1) If such date falls within a period for which We have accepted premium, coverage shall not terminate until the last day of such period; or

      (2) Coverage for any unmarried child who is medically certified as Disabled and dependent upon You shall not terminate upon reaching age 23 if the child continues to be both: (a) Disabled, and (b) dependent upon You for more than one-half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under this Contract and before the child attains 23. You must submit satisfactory proof of the disability and dependency to Us within 31 days following the child's attainment of age 23. As a condition to the continued coverage of a child as a disabled Dependent beyond age 23, We may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of age 23.

b. On the date of death of the Dependent; or

c. On the last day of any Contract Month on written request for termination of the Dependent's coverage made by the Subscriber and received by Us prior thereto; or

d. On the last day of any Contract Month in which a Dependent no longer resides, lives, or works in an area for which We are authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor.

3. Notwithstanding the provisions of Section 1, above, within 30 days of the death of the Subscriber, all remaining eligible Dependents may jointly elect in written notice to Us to continue this Contract with the eldest Dependent as Subscriber.

4. Notwithstanding the provisions of Section 2, above, within 30 days of a divorce, marriage of a child, or a child attaining age 23, the former Dependent losing coverage may elect to apply for coverage in his own name.

   Upon timely application, We will allow coverage under the name of the applicant without evidence of insurability at the then prevailing premium rate for persons of the same age, sex and geographical location.

   In the case of a change in marital status, the new Contract will have the same Effective Date as the Contract under which coverage was afforded prior to the loss of coverage. The rights provided under this Section 4 shall terminate if We do not receive the application within the 30-day period.

Article VII — Standard Provisions

1. **Claim Forms:** We will furnish to the Subscriber, the Hospital, and/or the Participant's Physician or Other Provider, upon receipt of a notice of claim or prior thereto, such forms as We usually furnish for filing Proof of Loss. If such forms are not furnished within 15 days after receipt of such notice by Us, the Participant shall be deemed to have complied with the requirements of this Contract as to Proof of Loss upon submitting, within the time fixed in the Contract for filing such Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

2. **Contract; Amendments:**

   a. This Contract and the application or applications for coverage by the Subscriber and any amendments, riders, or endorsements attached hereto, shall constitute the entire Contract. Any statements made shall be deemed representations and not warranties, and no statement made by the Subscriber in the application for this Contract shall be used in any contest or in defense of a claim hereunder unless a copy of the application is attached to this Contract when issued.

   b. Only Our President, Vice President, Secretary, or an Assistant Secretary has the power to change, modify, or waive the provisions of this Contract, and then only in writing prepared at the Administrative Office and attached or endorsed hereto. We shall not be bound by any promise or representation heretofore or hereafter made by or to any agent other than as specified above.

3. **Grace Period:** A grace period of: (a) ten days for monthly, or (b) 31 days for quarterly payment of premiums shall be allowed from the due date of each premium payment, during which grace period this Contract will continue in force, subject to its termination in accordance with the provisions hereof.

4. **Legal Actions:** No action at law or in equity shall be brought to recover on this Contract prior to the expiration of 60 days after written Proof of Loss has been filed in accordance with the requirements herein and no such action shall be brought at all unless brought within three years from the expiration of the time within which written Proof of Loss is required to be furnished by this Contract.

5. **Misstatement of Age:** In the event the age of a Participant has been misstated, the premium rate for such person shall be determined according to the correct age as provided in this Contract and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate at the true age of the Participant.

6. **Notice of Claim:** You shall give or cause to be given written notice to Us at Our Administrative Office at Richardson, Dallas County, Texas or Our duly authorized agent within 30 days or as soon as reasonably possible after any Participant receives any of the services for which benefits are provided herein. Notice given to any Hospital by the Participant at the time of admission as a patient shall satisfy this requirement.

7. **Physical Examinations and Autopsy:** We, at Our own expense, shall have the right and opportunity to examine the person of the Participant for whom claim is made, when and so often as We may reasonably require during the pendency of a claim hereunder and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.

8. **Proof of Loss:**

   a. Except for services or supplies provided by a Network Provider, written Proof of Loss must be furnished to Our Administrative Office at Richardson, Dallas County, Texas, or Our duly authorized agent, no later than 90 days from the date that the services or supplies are provided to the Participant. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity of the Subscriber, later than one year from the time proof is otherwise required.

   b. Written Proof of Loss for services or supplies provided by a Network Provider must be furnished to Us in strict compliance with the written contract between BCBSTX or another Blue Cross Plan and the Network Provider. In the event such written contract does not contain a time limitation for furnishing Proof of Loss, the provisions of Subsection a, above, shall be applicable.

9. **Reinstatement:** If default is made in the stipulated premium payments for this Contract, the subsequent acceptance of such premium payments by BCBSTX or any of Our duly authorized agents shall reinstate the Contract. For purposes of this Section 9, mere receipt and/or negotiation of a late premium payment does not constitute acceptance. The reinstated Contract shall cover only loss resulting from Accidental Injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than ten days after such date. In all other respects, the Subscriber and BCBSTX shall have the same rights hereunder as they had under the Contract immediately before the due date of the defaulted premiums, including the right of the Subscriber to apply the period of time this Contract was in effect immediately before the due date of the defaulted premiums toward satisfaction of any waiting periods for benefits, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium 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 60 days prior to the date of reinstatement.

10. **Time Limit on Certain Defenses:**

    a. After two years from the Effective Date of coverage for any Participant, no misstatements or omissions, except fraudulent misstatements or omissions, made in his application for coverage shall be used to void his coverage or to deny a claim for benefits on account of hospitalization or medical-surgical services provided after the expiration of such two-year period.

    b. No claim for loss incurred with respect to any Participant under this Contract on account of hospitalization or medical-surgical services provided after the two-year period from the date of issue of this Contract shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Participant's Effective Date of coverage under this Contract; provided, however, that this Subsection b shall not apply to a disease or physical condition for which a fraudulent misstatement or omission was made by the Subscriber in his application for coverage.

Article VIII — General Provisions

1. **Disclaimer:** We will not be liable for any act or omission by any Hospital, Physician, or Other Provider, their agents or employees, in caring for a Participant receiving services covered under this Contract, and no responsibility attaches hereunder for inability of any Hospital, Physician, or Other Provider to furnish accommodations or services. Benefits are subject to the rules and regulations of the Hospital, facility or other institution selected by the Participant, and are available only for sickness or injury acceptable to such Hospital, facility, or other institution.

2. **Disclosure Authorization:**

   a. In consideration of Our having waived physical examination in connection with the application, You, on behalf of Yourself and Your Dependents, shall be deemed to have authorized any attending Physician, Other Provider or Hospital to furnish Us all information and records or copies of records relating to the diagnosis, treatment, or care of any Participant included under this Contract; and such Participants shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

   b. As a condition to the continued coverage of a child as a disabled Dependent beyond the age of 23, We 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 age 23.

3. **Gender:** Use herein of a personal pronoun in the masculine gender shall be deemed to include the feminine unless the context clearly indicates the contrary.

4. **Non-Agency:** You understand that this Contract constitutes a contract solely between You and Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX is a Division of Health Care Service Corporation, a Mutual Legal Reserve Corporation, an Independent Licensee of the Blue Cross and Blue Shield Association. The license from the Association permits Blue Cross and Blue Shield of Texas to use the Blue Cross and Blue Shield Service Marks in the State of Texas. BCBSTX is not contracting as the agent of the Association. You also understand that You have not entered into this Contract based upon representations by any person other than BCBSTX. No person, entity, or organization other than BCBSTX shall be held accountable or liable to You for any of its obligations created under this Contract. This Section 4 shall not create any additional obligations whatsoever on the part BCBSTX other than those obligations created under other provisions of this Contract.

5. **Premiums:**

   a. The premium applicable to this Contract is determined by You, Your age, Your place of residence on each premium due date, certain health conditions or a combination of such health conditions, including but not limit to, whether or not You or a family member is a smoker or user of tobacco products, and the number and classification of the family members covered hereunder, if applicable, in accordance with the schedules filed with the Texas Department of Insurance. If both husband and wife are included on the same membership, Your premium will be based on the age of each adult.

   You shall notify Us in writing of any change in Your place of residence within 30 days of the date of change.

   Your place of residence means the address where You principally reside and regularly maintain physical presence.

   b. Notwithstanding the provisions of Subsection a, above, of this Section 5:

      (1) **Change in Premium Upon Notice:** We reserve the right to adjust the premium upon 30 days notice to You. Such adjustments in rates shall become effective on the date specified in said notice. Except for a change in the number and classification of a family member, or changes in premium resulting from a change in residence or age under Paragraph (2) and/or (3), below, no adjustment in premium rate shall be made within six months of the initial premium rate.

      (2) **Change of Residence:** If You change Your place of residence and such change results in a change in premium, the premium applicable to this Contract shall automatically change to the rate applicable to the new place of

residence effective on the first day of the Contract Month following the date of such change in residence. If such change is to a lower premium rate and You fail to notify Us in writing of such change prior to the date of change, Your right to refund of overpayment shall be limited to the overpayment for the six months immediately preceding the date of notification to Us.

(3) **Age:** If You and/or Your spouse attain an age which results in an increased premium rate, the premium applicable to this Contract shall automatically change to the rate applicable to the new age effective on the first day of the Contract Month following Your and/or Your spouse's birthday.

6. **Refund of Benefit Payments:** If and when We determine that benefit payments hereunder have been made erroneously but in good faith, We reserve the right to seek recovery of such benefit payments from the Participant, any other insurance company, or Provider of services to whom such payments were made. We reserve the right to offset subsequent benefit payments otherwise payable by the amount of any such overpayment.

7. **Review of Claim Determinations:**

   a. When a claim is submitted properly and received by Us, it will be processed to determine whether and in what amount benefits should be paid. Some claims take longer to process than others do because they require information not provided with the claim. Examples of such matters include determination of Medical Necessity.

      After processing the claim, We will determine and notify the Participant of the exact amount, if any, being paid on the claim; that the claim is being denied in whole or in part and the reason for denial; or that We require additional information before we can determine Our liability. If additional information is requested, it must be furnished before processing of the claim can be completed.

   b. Any Participant (or a parent if he is a minor) has the right to seek and obtain a full and fair review by Us of any determination of a claim, or any other determination made by Us of the Participant's benefits under this Contract.

      If a Participant believes We incorrectly denied all or part of his charges and wants to obtain a review of the benefit determination, he must:

      (1) Submit a written request for review mailed to Us at Our Administrative Office in Richardson, Dallas County, Texas. The request must state the Participant's full name and Subscriber identification number and the charges on the claim he wants reviewed.

      (2) Include in the written request the items of concern regarding Our determination and all additional information (including medical information) that the Participant believes has a bearing on why the determination was incorrect.

      On the basis of the information supplied with the request for review, together with any other information available to Us, We will review Our prior determination for correctness and make a new determination. The Participant will be notified in writing of Our decision and the reasons for it within 60 days of Our receipt of the request for review. This determination will be final unless additional information, which has not previously been available for review, is provided within 60 days of the Participant's receipt of the determination.

8. **State Government Programs:**

   a. Benefits for services or supplies under this Contract 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 21.4910 of the *Texas Insurance Code*.

   b. All benefits paid on behalf of a child or children under this Contract must be paid to the Texas Department of Human Services where:

      (1) The Texas Department of Human Services is paying benefits pursuant to Chapter 31 or 32 of the *Human Resources Code*; and

      (2) The parent who is covered by this Contract 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; and

(3) We receive written notice at Our Administrative Office, affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.

9. **Subrogation**: If We pay or provide benefits for You or Your Dependents under this Contract, We are subrogated to all rights of recovery which You or Your Dependent has in contract, tort or otherwise against any person, organization or insurer for the amount of benefits We have paid or provided. That means We may use Your rights to recover money through judgment, settlement or otherwise from any person, organization or insurer.

   For the purposes of this provision, *Subrogation* means the substitution of one person or entity (BCBSTX) in the place of another (You or Your Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

   Right of Reimbursement

   In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, We will have a right of reimbursement.

   If You or Your Dependent recovers money from any person, organization or insurer for an injury or condition for which We paid benefits under this Contract, You or Your Dependent agrees to reimburse Us from the recovered money for the amount of benefits paid or provided by Us. That means You or Your Dependent will pay Us the amount of money recovered through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits We paid or provided.

   Right to Recovery by Subrogation or Reimbursement

   You or Your Dependent agrees to promptly furnish to Us all information concerning Your or Your Dependent's rights of recovery from any person, organization or insurer and to fully assist and cooperate with Us in protecting and obtaining its reimbursement and subrogation rights. Your, Your Dependent or Your attorney will notify Us before settling any claim or suit so as to enable Us to enforce Our rights by participating in the settlement of the claim or suit. You or Your Dependent further agrees not to allow the reimbursement and subrogation rights BCBSTX to be limited or harmed by any acts or failure to act on the part of You or Your Dependent.

BlueCross BlueShield of Texas

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

Blue Cross and Blue Shield of Texas
(herein called "BCBSTX")

AMENDMENT TO THE CONTRACT

The following changes are effective on the Contract for all renewed plans on or after January 1, 2025.

This Amendment 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.

IT IS AGREED that the Contract to which this Amendment is attached, and becomes a part, is amended as stated below:

Unless otherwise required by Federal or state law, the terms of this Amendment supersede the terms of the Contract to which this Amendment is attached and becomes a part of the Contract.

"Contract" means "Contract," "Policy," "Benefit Book," or "Certificate" issued to you under the Contract.

Terms that are capitalized are terms that are defined in your Contract or this Amendment.

The following provisions are hereby removed, replaced, or added to the Contract:

I. If the following exclusion is in Your Contract, it is hereby removed:

- Any services or supplies for reduction mammoplasty.

II. The following are added to the Limitations and Exclusions section of Your Contract:

- Cannabis - this Contract does not cover cannabis. Cannabis means all parts of the plant genus cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

- Any of the following vitamin B12 testing:
  a. Testing or screening for a vitamin B12 deficiency in healthy, asymptomatic individuals
  b. Testing to screen or confirm a vitamin B12 deficiency
  c. Vitamin B12 testing within three (3) months of beginning treatment for a B12 deficiency

- Vitamin D testing – Routine screening for vitamin D deficiency with serum testing in asymptomatic individuals and/or during general encounters

- Hemoglobin A1c testing in any of the following situations:
  a. If You have had a blood transfusion within the past 120 days
  b. If You have a condition associated with increased red blood cell turnover; or
  c. If You are also being measured for fructosamine;

- Influenza Testing
  a. Viral culture testing for influenza in an outpatient setting
  b. Outpatient influenza testing in asymptomatic patients
  c. Serology testing for influenza under any circumstance

- Any of the following cardiac biomarker measurements:
  a. For the diagnosis of a heart attack if You have symptoms of acute coronary syndrome such as chest pains
  b. If You have symptoms of acute coronary syndrome and received services in a setting that cannot perform an evaluation for a heart attack, such as an independent lab or Physician's office

- Drug testing in an outpatient setting is not covered in the following situations:
  a. Testing to confirm the presence and/or amount of drugs in Your system when laboratory-based definitive drug testing is requested for larger than seven drug classes panels
  b. Use of proprietary drug tests such as ReskviewRX Plus
  c. Specific validity testing, including, but not limited to the following tests: urine-specific gravity, urine creatinine, pH, urine oxidant level, and genetic identity testing are included in the panel test and therefore will not be covered if submitted individually if a urine panel test was also ordered at the same time
  d. Testing for any American Medical Association definitive drug class codes
  e. Same-day testing for the same drug or metabolites from two different samples (e.g. both a blood and urine specimen)
  f. Testing of samples with abnormal validity tests
  g. Drug testing for patients in a facility setting (inpatient or outpatient) are not separately covered, as they are included in the daily charge at the facility
  h. Both qualitative (type of drug) testing and presumptive (to verify presence of drugs) testing on the same specimen

- Folate testing - Measurement of RBC folate. Measurement of serum folate concentration is only covered when You have been diagnosed with megaloblastic or macrocytic anemia and those conditions do not resolve after folic acid treatment.

- Pancreatic enzyme testing in any of the following situations:
  a. More than once per visit
  b. As part of ongoing assessment or therapy of chronic pancreatitis
  c. During a general exam without abnormal findings if You do not have symptoms and are not pregnant
  d. For measurement of the following biomarkers for the diagnoses or assessment of acute pancreatitis, prognosis and/or determination of severity of acute pancreatitis is not covered: measurement of both amylase AND serum lipase, serum trypsin/trypsinogen/TAP (trypsinogen activation peptide), C-Reactive Protein (CRP); Interleukin-6 (IL-6); Interleukin-8 (IL-8); or Procalcitonin.

- Cardiovascular disease risk assessment testing in any of the following situations:
  a. High-sensitivity C-Reactive Protein except when a risk-based treatment decision is not certain after having a quantitative risk assessment using American College of Cardiology/American Heart Association (ACC/AHA) calculator to calculate 10-year risk of cardiovascular disease (CVD)
  b. High-sensitivity C-Reactive Protein as a screening test for the general population or for monitoring response to therapy
  c. Measurement of high-sensitivity cardiac troponin T for cardiovascular risk assessment and stratification in the outpatient setting
  d. Homocysteine testing for cardiovascular disease risk assessment screening, evaluation and management

e. Novel cardiovascular biomarkers such as measurement of novel lipid and non-lipid biomarkers as an add on to LDL cholesterol in the risk assessment of cardiovascular disease;
f. Cardiovascular risk panels, consisting of multiple individual biomarkers intended to assess cardiac risk (other than simple lipid panels)
g. Serum intermediate density lipoprotein as an indicator of cardiovascular disease risk
h. Measurement of lipoprotein-associated phospholipase as an indicator of risk of cardiovascular disease
i. Measurement of secretory type II phospholipase in the assessment of cardiovascular risk for all indications
j. Measurement of long-chain omega-3 fatty acids in red blood cell membranes, including but not limited to its use as a cardiac risk factor
k. All other tests for assessing CHD risk

- Allergen testing in the following situations:
  a. Routine re-testing for confirmed allergies to the same allergens except in children and adolescents with positive food allergen results to monitor for allergy resolution
  b. The Antigen Leukocyte Antibody test (ALCAT)
  c. In-vitro testing of allergen specific IgG or non-specific IgG, IgA, IgM, and/or IgD in the evaluation of suspected allergy
  d. Basophil activation flow cytometry testing for measuring hypersensitivity to allergens
  e. In-vitro allergen testing using bead-based epitope assays
  f. In-vitro testing of allergen non-specific IgE

- The following testosterone tests:
  - Testing for serum-free testosterone and/or bioavailable testosterone as primary testing (i.e., in the absence of prior serum TOTAL testosterone testing)
  - Testing for serum total testosterone, free testosterone, and/or bioavailable testosterone in asymptomatic individuals or in individuals with non-specific symptoms
  - Testing for serum testosterone for the identification of androgen deficiency in women
  - Salivary testing for testosterone
  - Measurement of serum dihydrotestosterone in individuals except in diagnosing 5-alpha reductase deficiency in individuals with ambiguous genitalia, hypospadias, or microphallus

- Thyroid Disease Testing in the following situations:
  a. Testing for thyrotropin-releasing hormone (TRH) or thyroxine-binding globulin (TBG) for the evaluation of the cause of hyperthyroidism or hypothyroidism
  b. Testing for thyroid dysfunction during a general exam without abnormal findings for asymptomatic non-pregnant individuals

- Onychomycosis testing in the following situation:
  a. Nucleic acid testing, attenuated total-reflectance fourier transform infrared (ATR-FTIR) spectroscopy and testing for the presence of fungal-derived sterols (e.g. ergosterol) to screen for, diagnose, or confirm onychomycosis

Changes in 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.

Blue Cross and Blue Shield of Texas

By:

Jim Springfield
President,
Blue Cross and Blue Shield of Texas

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 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 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, TX 75266-0819.

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

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AMENDMENT TO THE CONTRACT

The following changes are effective on the Contract for all renewed plans on or after January 1, 2025.

This Amendment 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.

IT IS AGREED that the Contract to which this Amendment is attached, and becomes a part, is amended as stated below:

Unless otherwise required by Federal or state law, the terms of this Amendment supersede the terms of the Contract to which this Amendment is attached and becomes a part of the Contract. However, definitions set forth in this Amendment are for purposes of this Amendment only.

"Contract" means "Contract," "Policy," "Benefit Book," or "Certificate" issued to you under the Contract.

Terms that are capitalized are terms that are defined in your Contract or this Amendment.

The following provisions are hereby removed, replaced, or added to the Contract:

I. The following Section is added to Your Contract:

Coordination of Benefits

Coordination of Benefits ("COB") applies when You have health care coverage through more than one Health Care Plan. The order of benefit determination rules govern the order in which each Health Care Plan will pay a claim for benefits. The Health Care Plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The Health Care Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total Allowable Expense.

For purposes of this section only, the following words and phrases have the following meanings:

Allowable Expense means a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Health Care Plan covering the person for whom claim is made. When a Health Care Plan (including this Health Care Plan) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable Expense and a benefit paid. An expense that is not covered by any plan covering the person is not an Allowable Expense. In addition, any expense that a health care Provider or Physician by law or in accord with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the plans provides coverage for private hospital room expenses.
2. If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, Allowed Amounts, or relative value schedule reimbursement methodology, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, Allowed Amounts, relative value schedule reimbursement methodology, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the Allowable Expense for all plans. However, if the health care Provider or Physician has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the health care Provider's or Physician's contract permits, the negotiated fee or payment must be the Allowable Expense used by the secondary plan to determine its benefits.
5. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, prior authorization of admissions, and preferred health care Provider and Physician arrangements.

Allowed Amount means the amount of a billed charge that a carrier determines to be covered for services provided by a nonpreferred health care Provider or Physician. The Allowed Amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the insured is responsible.

Closed Panel Health Care Plan means a plan that provides health care benefits to covered persons primarily in the form of services through a panel of health care Providers and Physicians that have contracted with or are employed by the Health Care Plan, and that excludes coverage for services provided by other health care Providers and Physicians, except in cases of emergency or referral by a panel member.

Custodial Parent means the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

Health Care Plan means any of the following (including this Health Care Plan) that provide benefits or services for, or by reason of, medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

Group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred Provider benefit plans and exclusive Provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

Health Care Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; Hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Health Care Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with like benefits, and may apply other separate COB provisions to coordinate other benefits.

The order of benefit determination rules determine whether this Health Care Plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this Health Care Plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this Health Care Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits equal 100 percent of the total Allowable Expense.

BCBSTX has the right to coordinate benefits between this Health Care Plan and any other Health Care Plan covering you.

When a person is covered by two or more plans, the rules establishing the order of benefit determination between this Plan and any other Health Care Plan covering you on whose behalf a claim is made are as follows:

1. The benefits of a Health Care Plan that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Plan unless the provisions of both Health Care Plans state that the complying Health Care Plan is primary.
2. If according to the rules set forth below in this section the benefits of another Health Care Plan that contains a provision coordinating its benefits with this Health Care Plan would be determined before the benefits of this Health Care Plan have been determined, the benefits of the other Health Care Plan will be considered before the determination of benefits under this Health Care Plan.

The order of benefits for your claim relating to the paragraphs above, is determined using the first of the following rules that applies:

1. **Nondependent or Dependent.** The Health Care Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the Health Care Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Care Plan covering the person as a dependent and primary to the Health Care Plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the Health Care Plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Health Care Plan is the primary plan. An example includes a retired employee.

2. **Dependent Child Covered Under More Than One Health Care Plan.** Unless there is a court order stating otherwise, Health Care Plans covering a Dependent child must determine the order of benefits using the following rules that apply:

    a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

        i. The Health Care Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or

        ii. If both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan.

    b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:

        i. if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.

        ii. if a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 2.a. must determine the order of benefits.

        iii. if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 2.a. must determine the order of benefits.

        iv. if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

            1. the Health Care Plan covering the Custodial Parent;

            2. the Health Care Plan covering the spouse of the Custodial Parent;

            3. the Health Care Plan covering the non-Custodial Parent; then

            4. the Health Care Plan covering the spouse of the non-Custodial Parent.

    c. For a Dependent child covered under more than one Health Care Plan of individuals who are not the parents of the child, the provisions of 2.a or 2.b. must determine the order of benefits as if those individuals were the parents of the child.

    d. For a Dependent child who has coverage under either or both parents' Health Care Plans and has his or her own coverage as a Dependent under a spouse's Health Care Plan, paragraph 5. below applies.

    e. In the event the Dependent child's coverage under the spouse's Health Care Plan began on the same date as the Dependent child's coverage under either or both parents' Health Care Plans, the order of benefits must be determined by applying the birthday rule in 2.a. to the Dependent child's parent(s) and the Dependent's spouse.

3. **Active, Retired, or Laid-off Employee.** The Health Care Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Health Care Plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the Health Care Plan that covers the same person as a retired or laid-off employee or as a Dependent of a retired or laid-off employee does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Health Care Plan, the Health Care Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Health Care Plan does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.

5. **Longer or Shorter Length of Coverage.** The Health Care Plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the Health Care Plan that has covered the person the shorter period is the secondary plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses must be shared equally between the Health Care Plans meeting the definition of Health Care Plan. In addition, this Health Care Plan will not pay more than it would have paid had it been the primary plan.

When this Health Care Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Health Care Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Health Care Plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Health Care Plans for the claim equal 100 percent of the total Allowable Expense for that claim. In addition, the secondary plan must credit to its plan deductible (if applicable) any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed Panel Health Care Plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one Closed Panel Health Care Plan, COB must not apply between that Health Care Plan and other Closed Panel Health Care Plans.

For purposes of this provision, BCBSTX may, subject to applicable confidentiality requirements set forth in this Plan, release to or obtain from any insurance company or other organization necessary information under this provision. If you claim benefits under this Plan, you must furnish all information deemed necessary by Us to implement this provision.

None of the above rules as to coordination of benefits shall delay your health services covered under this Plan.

Whenever payments have been made by BCBSTX with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Part, We shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as We shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

A payment made under another Health Care Plan may include an amount that should have been paid under this Health Care Plan. If it does, BCBSTX may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Health Care Plan. BCBSTX will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Changes in 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.

By:

James Springfield
President, Blue Cross and Blue Shield of Texas

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 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 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, TX 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, 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

BlueCross BlueShield of Texas

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

Blue Cross and Blue Shield of Texas
(herein called "BCBSTX")

AMENDMENT TO THE CONTRACT

The following changes are effective on the Contract for all renewed plans on or after January 1, 2024.

This Amendment 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.

The Contract to which this Amendment is attached, and becomes a part, is amended as stated below:

I. The following definition is added to the DEFINITIONS section of Your Contract:

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

II. The following definition is replaced in the DEFINITIONS section of Your Contract:

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

a. 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
b. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
c. Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
d. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.
e. If more than one health intervention meets the requirements listed above, Medically Necessary means the most cost effective in terms of type of intervention or settings, frequency, extent, or duration, which is safe and effective for the patient's illness, injury, or disease and supports improved health.

The medical staff of BCBSTX shall determine whether a service or supply is Medically Necessary under the Contract and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition. BCBSTX does not determine course of treatment or whether particular health care services are received. The decision

regarding the course of treatment and receipt of particular health care services is a matter entirely between the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider.

III. The following is added to the provision explaining "how to receive Network Benefits" under the "How the Medical Plan Works" section of Your Contract:

However, if You

- pay the Provider a rate less than the average discounted rate which would be paid by BCBSTX to a Network Provider directly for a covered and Medically Necessary service or supply, and;
- the Provider does not submit a claim to BCBSTX for that service or supply;

then You may submit the appropriate documentation with a claim form to BCBSTX, and allowable credit will, as applicable, be applied towards Your in-network annual Deductible and Out-of-Pocket Maximums.

IV. The following is added to the provision explaining "if You choose a Provider outside the Network" under the "How the Medical Plan Works" section of Your Contract:

However, if You

- pay the Provider a rate less than the average discounted rate which would be paid by BCBSTX to a Network Provider directly for a covered and Medically Necessary service or supply, and;
- the Provider does not submit a claim to BCBSTX for that service or supply;

then You may submit the appropriate documentation with a claim form to BCBSTX, and allowable credit will, as applicable, be applied towards Your in-network annual Deductible and Out-of-Pocket Maximums.

V. The following benefits are hereby added to Your Contract under the Special Benefit Provisions section:

Benefits for Biomarker Testing
Covered services for Medically Necessary *Biomarker Testing* for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a Participant's disease or condition to guide treatment when the test is supported by medical and scientific evidence, including:

1. A labeled indication for a test approved or cleared by the FDA;
2. An indicated test for a drug approved by the FDA;
3. A national coverage determination made by CMS or a local coverage determination made by a Medicare administrative contractor;
4. Nationally recognized clinical practice guidelines; or
5. Consensus statements.

Biomarker Testing will be covered only when use of *Biomarker Testing* provides clinical utility because use of the test for the condition is evidence-based, is scientifically valid based on the medical and scientific evidence, informs the Participant's outcome and a Provider's clinical decision, and predominantly addresses the acute or chronic issue for which the test is ordered. This coverage will be provided in a manner that limits disruptions in care, including limiting the number of biopsies and biospecimen samples.

Biomarker means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to the specific therapeutic intervention. Includes gene mutations and protein expression.

Biomarker Testing means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes single-analyte tests, multiplex panel tests and whole genome sequencing.

Benefits for Fertility Preservation Services
Benefits are available for *Fertility Preservation Services* for Participants who will receive Medically Necessary treatment for cancer, including surgery, chemotherapy, or radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility.

The *Fertility Preservation Services* must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Fertility Preservation Services means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue; and does not include the storage of such unfertilized genetic materials.

VI. The following benefit is hereby replaced as follows:

Benefits for Organ and Tissue Transplants

a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

   (1) The transplant procedure is not Experimental/Investigational in nature;
   (2) Donated human organs or tissue or an FDA-approved artificial device are used; and
   (3) The recipient is a Participant under the Contract; and
   (4) The transplant procedure is Prior Authorized as required under the Contract; and
   (5) The Participant meets all of the criteria established by BCBSTX in pertinent written medical policies; and
   (6) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

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

   Benefits will be available for:
   (1) A recipient who is covered under this Contract;
   (2) A donor who is a Participant under this Contract; or
   (3) A donor who is not a Participant under this Contract.

c. Covered services and supplies include services and supplies provided for the:
   (1) Donor search and acceptability testing of potential live donors; and
   (2) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
   (3) Removal of organs or tissues from living or deceased donors; and
   (4) Transportation and short-term storage of donated organs or tissues.

d. No benefits are available for a Participant for the following services or supplies:
   (1) Living and/or travel expenses of the recipient or a live donor;
   (2) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
   (3) Purchase of the organ or tissue other than payment for covered services and supplies identified above;
   (4) Organ or tissue (xenograft) obtained from another species;
   (5) If the transplant operation or post-transplant care is performed in China or another country known to have participated in forced organ harvesting; or
   (6) The human organ to be transplanted was procured by a sale or donation originating in China or another country known to have participated in forced organ harvesting.

e. Prior Authorization is required for any organ or tissue transplant.
   (1) Such specific Prior Authorization is required even if the patient is already a patient in a Hospital under another Prior Authorization.
   (2) At the time of Prior Authorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which BCBSTX considers to be Experimental/Investigational.

VII. The following provision is hereby added as follows under the Prescription Drug Program section:

Step Therapy
For treatment of Serious Mental Illness (if covered by Your Contract) for Participants 18 years or older, for Covered Drugs approved by the FDA will not require that the Participant:

1. Fail to successfully respond to more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed drug; or
2. Prove a history of failure of more than one different drug for each drug prescribed, excluding the generic or pharmaceutical equivalent of the prescribed.

Step Therapy may be required for a trial of a generic or pharmaceutical equivalent of a prescribed prescription drug as a condition of continued coverage of the prescribed drug only:

1. Once in a Calendar Year; and
2. If the generic or equivalent drug is added to the Contract's Drug List.

VIII. The following language is added to the *Prescription Contraceptive Drugs and Devices and Related Services* provision under Your Prescription Drug Program section as follows:

Covered prescription contraceptives may be obtained as follows:
- An initial 3-month supply at one time;
- Up to a 12-month supply at one time for subsequent refills; or
- A maximum of 12-month supply during each 12-month period.

IX. The following provisions are added to Your Prescription Drug Program section:

Participating Pharmacy & Non-Participating Pharmacy
When you go to a Participating or Non-Participating Pharmacy, if You:

- pay the Pharmacy a rate less than the average discounted rate which would be paid by BCBSTX to a Participating Pharmacy directly for a covered and Medically Necessary service or supply, and
- the Pharmacy does not submit a claim to BCBSTX for that service or supply;

then You may submit the appropriate documentation with a claim form to BCBSTX, and allowable credit will, as applicable, be applied towards Your in-network annual Deductible and Out-of-Pocket Maximums.

Clinician Administered Drugs
For Participants with a chronic, complex, rare, or life-threatening medical condition, Covered Drugs that will be administered by a Provider in a physician's office may be obtained from a non-Participating Pharmacy by the Provider, after the Provider has determined that disease progression, patient harm, or death is probable, or where the Provider has concerns about patient adherence or timely delivery. These services are covered under the medical benefit and the cost-sharing requirements will be the same as if they were obtained from a Participating Pharmacy.

X. The following language is hereby added or replaced as follows under the Prescription Drug Program section of Your Contract:

If a Covered Drug was paid for using any third-party payments, financial assistance, discount, product voucher, or other reduction in out-of-pocket expenses made by You or on Your behalf, that amount will be applied to Your cost-sharing requirements (including deductible, copayment, or out-of-pocket maximum).

XI. The following Exclusion is added or replaced under the Prescription Drug Program section of Your Contract:

Drugs purchased from a Non-Participating Pharmacy in the Service Area, except as provided in *Clinician-Administered Drugs* under the Prescription Drug Program section of Your Contract.

Changes in 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.

Blue Cross and Blue Shield of Texas
By:

James Springfield
President,
Blue Cross and Blue Shield of Texas

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 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 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, TX 75266-0819.

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

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of Texas

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Blue Cross and Blue Shield of Texas
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AMENDMENT TO THE CONTRACT

The following changes are effective on the Contract for all renewed plans on or after January 1, 2024.

This Amendment 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.

The Contract to which this Amendment is attached, and becomes a part, is amended as stated below:

I. If Your Contract includes prescription drug coverage, please note that any cost to You for retail and mail order drugs will be based on day supply dispensed (Example: 1–30-day supply, 31–60-day supply, 61-90 day supply).

II. If Your Contract includes prescription drug coverage, the following provision entitled MedsYourWay™ is added to Your Contract under the Prescription Drug Program section:

***MedsYourWay*™**
MedsYourWay™ ("MedsYourWay") may lower Your out-of-pocket costs for select Covered Drugs purchased at select Network retail Pharmacies. MedsYourWay is a program that automatically compares available drug discount card prices and prices under Your Contract for select Covered Drugs and establishes Your out-of-pocket cost to the lower price available. At the time You submit or pick up Your prescription, present Your BCBSTX Identification Card to the pharmacist. This will identify You as a participant in MedsYourWay and allow You the lower price available for select Covered Drugs.

The amount You pay for Your prescription will be applied, if applicable, to Your Deductible and out-of-pocket maximum. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply, and certain Covered Drugs or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select Covered Drugs depending upon which retail Pharmacy is utilized. For additional information regarding MedsYourWay, please contact a customer service representative at the toll-free telephone number on the back of Your Identification Card. Participation in MedsYourWay is not mandatory and You may choose not to participate in the program at any time by contacting Your customer service representative at the toll-free telephone number on the back of Your Identification Card. In the event MedsYourWay fails to provide, or continue to provide, the benefit as stated, there will be no impact to You. In such an event, You will pay the Contract's Pharmacy benefit Copayment Amount.

III. If Your Contract includes prescription drug coverage, the following provision is added to Your Contract under the Prescription Drug Program section:

Multi-Category Split-Fill Program

If this is Your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if You have not filled one of these medications within 120 days, You may only be able to receive a partial fill (14–15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for You. If You receive a partial fill, Your Copayment Amount and/or Coinsurance Amount, after Your Deductible (if applicable), will be adjusted to align with the quantity of medication dispensed. If the medication is working for You and Your Physician wants You to continue on this medication, You may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the www.bcbstx.com/rx-drugs/pharmacy/pharmacy-programs website.

Day Supply

In order to be eligible for coverage under this Benefit Section, the prescribed day supply must be Medically Necessary and must not exceed the maximum day supply limitation described in this Benefit Section. Benefits under this Benefit Section may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation. Coverage for specialty drugs are limited to a 30-day supply. However, some specialty drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30 day-supply, if allowed by your plan benefits. For information about benefits for these drugs call the customer service toll-free telephone number located on your Identification Card. Early prescription refills of topical eye medication used to treat a chronic condition of the eye will be eligible for coverage after at least 75% of the predicted days of use, and the early refills requested do not exceed the total number of refills prescribed by the Physician or Optometrist. Benefits for prescription inhalants will not be restricted on the number of days before an inhaler refill may be obtained. You may receive coverage for up to a 12-month supply for dispensed contraceptive drugs and products that are covered under this Benefit Section. For additional information about early refills, please see the Prescription Refills provision.

IV. If Your Contract includes prescription drug coverage, the following exclusions are added or replaced:

Devices, technologies, and/or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliances, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections and those devices listed as diabetes supplies).

Drugs/products that are not included on the drug list, but are specifically covered elsewhere in this Contract, and/or such coverage is required in accordance with applicable law or regulatory guideline.

New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield of Texas may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your benefit, the drug purchased will not be covered under any Benefit level.

Any procedures, equipment, services, supplies, or charges for abortions except for abortions to terminate a pregnancy that, as certified by a physician, places the woman in danger of death.

V. **If Your Contract includes prescription drug coverage, the exclusion specific to Legend Drugs is removed.**

VI. **If Your Contract includes prescription drug coverage, any references to limitations on quantities dispensed are hereby removed.**

VII. **In the DEFINITIONS section of Your Contract, "Professional Other Provider" is amended as follows:**

b. **Professional Other Provider** – a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:

(1) Advanced Practice Nurse
(2) Doctor of Chiropractic
(3) Doctor of Dentistry
(4) Doctor of Optometry
(5) Doctor of Podiatry
(6) Doctor in Psychology
(7) Licensed Acupuncturist
(8) Licensed Audiologist
(9) Licensed Clinical Social Worker
(10) Licensed Dietitian
(11) Licensed Hearing Instrument Fitter and Dispenser
(12) Licensed Physical Therapist
(13) Licensed Occupational Therapist
(14) Licensed Speech-Language Pathologist
(15) Nurse First Assistant
(16) Physician Assistant
(17) Surgical Assistant

Such terms as used herein, unless otherwise defined in this Contract, shall have the meaning assigned to them by the *Texas Insurance Code*. In states where there is a licensure requirement, such Other Providers must be licensed by the appropriate state administrative agency.

Changes in 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.

Blue Cross and Blue Shield of Texas

By:

Jim Springfield
President,
Blue Cross and Blue Shield of Texas

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 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 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, TX 75266-0819.

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

This amendment is to advise You of P.O. Box updates within Your Contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation.

This Amendment is issued to and made a part of Your Contract to which it is attached. Your Contract is hereby amended as indicated below:

1. **The Important Notice section in the Toll-Free Notice is amended to read as follows:**

   - You may also write to Blue Cross and Blue Shield of Texas at:
     P.O. Box 660819
     Dallas, Texas 75266-0819

2. **If Your Contract includes a Questions and Complaints section, Your Contract is amended as follows:**

   Contact: Blue Cross and Blue Shield
   300 East Randolph Street
   Chicago, IL 60601-5009

   You may also contact us using the toll-free number located on the back of your BCBSTX's member identification card.

3. **If Your Contract includes a BlueCard Program Savings section, Your Contract is amended as follows:**

   Below are some frequently - asked questions that will help illustrate the claims calculation. For further information, you may write BCBSTX at Blue Cross Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044.

GRANDFATHERED HEALTH PLAN DISCLOSURE

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 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 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, TX 75266-0819.

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

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.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: James Springfield President

AMENDMENT

This Amendment is to advise you of a change to your Policy with Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation.

This Amendment is issued to and made a part of your Policy (the Plan) to which it is attached.

The section entitled **Have a complaint or need help?** Is hereby amended as follows:

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

El Departmento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

Changes in 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 Policy to which this amendment is attached will remain in full force and effect.

By: President, Blue Cross and Blue Shield of Texas

An Amendment

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

Your Policy and any Amendments attached to the Policy are amended as follows:

If your Policy has Out of Network benefits, the following provisions are added:

Balance Billing and Other Protections

Federal requirements, including but not limited to the Consolidated Appropriations Act, may impact your benefits. BCBSTX will apply federal requirements to your Policy, where applicable.

For some types of Out-of-Network care, your health care Provider may not bill you more than your Network cost-sharing levels. If you receive the types of care listed below, your cost-share will be calculated as if you received services from a Network Provider. Those cost-share amounts will apply to any Network Deductible and Out-of-Pocket Maximums.

- Emergency Care from facilities or Providers who do not participate in your network;
- Care furnished by non-participating Providers during your visit to a Network facility; and
- Air ambulance services from non-participating Providers, if your plan covers Network air ambulance services.

There are limited instances when an Out-of-Network Provider of the care listed above may send you a bill for up to the amount of that Provider's billed charges. You are only responsible for payment of the Out-of-Network Provider's billed charges if, in advance of receiving services, you signed a written notice that informed you of:

- the Provider's Out-of-Network status;
- in the case of services received from an Out-of-Network Provider at a Network facility, a list of Network Providers at the facility who could offer the same services;
- information about whether Prior Authorization or other care management limitations may be required in advance of services; and
- a good faith estimate of the Provider's charges.

Your Provider cannot ask you to be responsible for paying billed charges for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other specialists as may be defined by applicable law.

Coverage Determinations

Certain services are covered pursuant to BCBSTX medical policies and clinical procedure and coding policies, which are updated throughout the Calendar Year. The medical policies are guides considered by BCBSTX when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is an Eligible Expense or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Plan. The most up-to-date medical and clinical procedure and coding policies are available at

www.bcbstx.com, or contact customer service at the toll-free number on the back of your Identification Card.

If your Policy has Out of Network benefits, the Allowable Amount definition in the **Definitions**; section of your Policy or Amendment, if applicable, is amended to add the following paragraphs:

For non-Emergency Care provided by an Out-of-Network Provider when a contracting provider is not reasonably available as defined by applicable law or when services are pre-approved or preauthorized based upon the unavailability of a Preferred Provider and balance billing is not prohibited by Texas law – The Allowable Amount will be BCBSTX's usual and customary charge as defined by Texas law or as prescribed under applicable law and regulations, or at a rate agreed to between BCBSTX and the Out-of-Network Provider, not to exceed billed charges.

For Out-of-Network Emergency Care, care provided by an Out-of-Network facility-based Provider in a Network Hospital, ambulatory surgery center or birthing center, or services provided by an Out-of-Network Laboratory or Diagnostic Imaging Service in connection with care delivered by a Network Provider – the Allowable Amount will be the BCBSTX's usual and customary rate or at a rate agreed to between BCBSTX and the Out-of-Network Provider as prescribed by the Texas Insurance Code, not to exceed billed charges. BCBSTX's usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less that the non-contracting Allowable Amount as defined in this Policy.

If your Policy has Preauthorization Requirements The following provision is added:

Some Texas licensed Providers may qualify for an exemption from required Prior Authorization requirements for a particular health care service if the Provider met criteria set forth by applicable law for the particular health care service. If so, Prior Authorization is not required for a particular service where an exemption applies and will not be denied based on Medical Necessity or medical appropriateness of care. Other providers providing your care may not be exempt from such requirements. Exemptions do not apply for services that are materially misrepresented or where the Provider failed to substantially perform the particular service.

The **Medical Benefits**; section of your Policy or Amendment, if applicable, is amended by deleting the Telehealth Services and Telemedicine Services benefit and replacing it with following benefits:

Teledentistry Dental Services, Telehealth Services and Telemedicine Services.

The **Medical Benefits**; **Benefits for Tests for Detection of Colorectal Cancer** provision of your Policy is amended by deleting the provision and replacing it with the following:

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer for Participants who are 45 years of age or older and who are at normal risk for developing colon cancer:

- All colorectal cancer examinations, preventive services, and laboratory test 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
- 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 a Network Provider will not be subject to Deductible, Copayment Amounts or Coinsurance Amounts.

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

The **Medical Benefits**; **Benefits for Early Detection Test for Ovarian Cancer** provision of your Policy is amended by deleting the provision and replacing it with the following:

Benefits for Early Detection Test for Ovarian Cancer

Benefits are available for

- a CA 125 blood test; and
- any other test or screenings approved by the United States Food and Drug Administration for the detection of ovarian cancer.

Benefits are available once every twelve months for each woman enrolled in the Plan who is age 18 years of age or older. Benefits are subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally.

If your Policy has Out of Network benefits The **Medical Benefits**; **Benefits for Emergency Care p**rovision of your Policy or Amendment, if applicable, is amended by adding the following:

For Out-of-Network Emergency Care services rendered by non-contracting Providers, the Allowable Amount shall be BCBSTX’s usual and customary rate or at a rate agreed to between BCBSTX and the noncontracting Provider, not to exceed billed charges. BCBSTX’s usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less that the non-contracting Allowable Amount as defined in this Policy.

The **Your Medical Benefits**; **Benefits for Diagnostic Mammogram** provision of your Policy is amended by deleting the provision and replacing it with the following:

Benefits for Diagnostic Mammography and Other Breast Imaging
Diagnostic Mammograms are Imaging is covered to the same extent as Benefits for Mammogram Screenings as described in the Preventive Services but without Participant age restrictions.
In addition to the applicable terms provided in the DEFINITIONS section of the Benefit Booklet, the following term will apply specifically to this provision.

Diagnostic Mammogram Imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

1. a subjective or objective abnormality detected by a Physician or patient in a breast;
2. an abnormality seen by a Physician on a screening mammogram;
3. an abnormality previously identified by a Physician as probably benign in a breast for which follow- up imaging is recommended by a Physician; or
4. an individual with a personal history of breast cancer or dense breast tissue.

The Copayment Amounts and Coinsurance Amounts shown on your Schedule(s) of Coverage, if applicable, for Preventive Services will apply, after the Calendar Year Deductible.

The **Medical Benefits**; section of your Policy is amended to add the following benefit:

Benefits for Emergency Refills of Insulin or Insulin-Related Equipment and Supplies

A pharmacist may exercise their professional judgement in refilling a Prescription Order for Insulin or Insulin-Related Equipment or Supplies without the authorization of the prescribing Health Care Practitioner in the following situations:

- The pharmacist is unable to contact your Health Care Practitioner after reasonable effort;
- The pharmacist has documentation showing the patient was previously prescribed insulin or insulin-related equipment or supplies by a Health Care Practitioner; and
- The pharmacist accesses the patient to determine whether the emergency refill is appropriate.

The quantity of an emergency refill will be the smallest available package and will not exceed a 30-day supply.

In addition to the applicable terms provided in the **Definitions** section of the Policy the following terms will apply specifically to this provision.

Insulin means an insulin analog and an insulin-like medication, regardless of the activation period or whether the solution is mixed before the prescription is dispensed.

Insulin-Related Equipment or Supplies means needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and text strips but does not include insulin pumps.

You are responsible for the same Deductibles, Copayment Amounts, Coinsurance Amounts and any pricing differences that may apply to the items dispensed in the same manner as for nonemergency refills of diabetes equipment or supplies.

The **Medical Benefits**; section of your Policy is amended to add the following benefit:

Insulin Drug Program
The total amount you may pay for a Covered Drug that contains insulin and is used to treat diabetes will not exceed will not exceed $25 per prescription up to a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription. The preferred

insulin drugs are identified on your Drug List, if applicable, and does not include an insulin drug administered intravenously.

Insulin drugs obtained from a non-Participating Pharmacy, if applicable, or not identified as a preferred insulin drug, if applicable, may be subject to Copayment Amount, Coinsurance Amount, Deductibles or dollar maximums, if applicable.

Exceptions will not be made for drugs not identified as a preferred insulin drug or for an excluded drug.

The **Definitions** section of your Policy is amended by adding the following definition:

Teledentistry Dental Service means a health care service delivered by a Dentist, or a health professional acting under the delegation and supervision of a Dentist, acting within the scope of the Dentist 's or health professional's license or certification to a patient at a different physical location than the Dentist or health professional using telecommunications or information technology.

The **Definitions** section of your Policy is amended by deleting the definition of Telehealth Service and replacing it with the following definition:

Telehealth Service means a health service, other than a Telemedicine Medical Service or a Teledentistry Dental Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Changes in 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 Policy to which this amendment is attached will remain in full force and effect. The above changes are effective on January 1, 2022.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: 

James Springfield
President

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 Policy.

Your Policy and any Amendments attached to the Policy are amended as follows:

The **GENERAL PROVISIONS** section of your Policy is amended by adding the following provisions:

COVID-19

Coverage under this Policy does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving benefits under this plan.

Eligibility Rules

No eligibility rules or variations in premium will be imposed based on your political affiliation or expression.

Paper Check – Automatic Clearing House/Electronic Funds Transfer

BCBSTX will not charge an additional fee to a Payee if such person elects to receive the payment by paper check instead of by an automated clearinghouse transaction or other electronic funds transfer.

In addition to the DEFINITIONS of this Policy, the following definition is applicable to this provision:

- "Payee" means individual who resides in this state or a corporation, trust, partnership, association, or other private legal entity authorized to do business in this state that receives money as payment under an agreement.

Changes in 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 Benefit Booklet to which this amendment is attached will remain in full force and effect. The above changes are effective on September 1, 2021.

Blue Cross and Blue Shield of Texas (BCBSTX)

By: 

James Springfield
President

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.

BlueCross BlueShield of Texas

Blue Cross and Blue Shield of Texas
(herein called "BCBSTX")

MANDATED HEALTH BENEFITS AMENDMENT

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.

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

This Amendment is issued to and made a part of your Individual Insurance Contract to which it is attached. This Amendment supersedes and replaces all previously issued Amendments. If this amendment conflicts with the benefit provisions of your plan, the greater benefit will apply. The Insurance Contract is hereby amended as indicated below:

1. Insurance Contract section entitled Definitions is hereby amended as follows:

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

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

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses.) For purposes of this definition, a wig or hairpiece is not considered Prosthetic Appliances.

Reconstructive Surgery for Craniofacial Abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

2. Insurance Contract section regarding covered services is hereby amended as follows:

Benefits for Behavioral or Mental Health Services
If your plan includes coverage for behavioral or mental health, all covered services are provided under the same terms and conditions applicable to this plan's medical and surgical benefits and coverage. Any quantitative or non-quantitative limitations applied will not be more restrictive than quantitative or nonquantitative treatment limitations imposed on coverage of benefits for medical or surgical expenses.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer
Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the Plan who is 18 years of age or older for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Certain Tests for Detection of Prostate Cancer
Benefits are available for an annual medically recognized diagnostic, physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least fifty (50) years of age and asymptomatic; or at least forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits are subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally.

Benefits for Certain Therapies for Children with Developmental Delays
Developmental Delays means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Individualized Family Service Plan means an initial and ongoing treatment plan developed by the Interagency Council on Early Childhood Intervention

Medical-Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas Human Resources Code.
Such therapies include:

- Occupational therapy evaluations and services;
- Physical therapy evaluations and services;
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations.

The Individualized Family Service Plan must be submitted to BCBSTX prior to the commencement of services and when the Individualized Family Service Plan is altered.

After the age of 3 when services under the Individualized Family Service Plan are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, define terms, limitations and exclusions, and benefit maximums.

Benefits for Childhood Immunizations
Benefits for *Medical-Surgical Expense* incurred by a Dependent child from birth up to the child's sixth birthdate for childhood immunizations will be determined at 100% of the Allowable Amount for Network and Out-of-Network Benefits. The Deductible, Coinsurance Amount, and Copayment Amounts, if any, will not be applicable.
Benefits are available for:

(a) Diphtheria,
(b) Hemophilus influenza type b,
(c) Hepatitis B,
(d) Measles,
(e) Mumps,
(f) Pertussis,
(g) Polio,
(h) Rubella,
(i) Tetanus,
(j) Varicella, and
(k) Any other immunization that is required by law for the child.

Allergy injections are not considered immunizations under this benefit provision.

Benefits for Cosmetic, Reconstructive or Plastic Surgery
The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery;
- Surgery performed on a newborn child for the treatment or correction of a congenital defect (other than conditions of the breast); or
- Reconstructive Surgery for Craniofacial Abnormalities; or
- Reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy. 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:
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection.

Benefits for Diagnostic Mammography and Other Breast Imaging
Diagnostic Imaging is covered to the same extent as Benefits for Mammogram Screening but without Participant age restrictions.

In addition to the applicable terms provided in the Definitions section of the Insurance Contract, the following term will apply specifically to this provision.

Diagnostic Mammogram means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging that is designed to evaluate:

1. a subjective or objective abnormality detected by a Physician in a breast;
2. an abnormality seen by a Physician on a screening mammogram;
3. an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or
4. an individual with a personal history of breast cancer or dense tissue.

The Copayment Amounts and Coinsurance Amounts for Preventive Services, if applicable, will apply.

Benefits for Early Detection Test for Cardiovascular Disease
Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five 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 Individual 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.

Early detection tests for cardiovascular disease are limited to one every 5 years.

Benefits for Early Detection Test for Ovarian Cancer
Benefits are available for a CA 125 blood test; and any other test or screenings approved by the United States Food and Drug Administration for the detection of ovarian cancer.

Benefits are available once every twelve months for each woman enrolled in the Plan who is age 18 years of age and older. Benefits are subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally.

Benefits for Foot Orthotics
Medically Necessary foot orthotics that are consistent with the Medicare Benefits Policy Manual are covered subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally. There is no Calendar Year maximum. This is in addition to, and does not affect, the coverage for Podiatric appliances shown in **Treatment of Diabetes**.

Benefits for Hearing Aids
Covered Services and equipment, which require prior authorization, include one audiometric examination to determine type and extent of hearing loss once every thirty-six (36) months and the fitting and purchase of hearing aid device(s). Coverage also includes fitting and dispensing services, the provision of ear molds as necessary to maintain optimal fit of hearing aids and Habilitation and Rehabilitation Services. Exclusions are listed in Limitations and Exclusions.

Benefits for Mammography Screening
Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant (35) years of age and older except that benefits will not be available for more than one routine mammography screening each Calendar Year. Low-dose mammography includes digital mammography or breast tomosynthesis.

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. Deductibles, Copayment Amounts, Coinsurance Amounts will not apply to certain orally administered anticancer medications when received from a Participating Provider. Coverage of prescribed orally administered anticancer medication will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

If you plan includes prescription drug coverage, benefit will be paid utilizing those benefits. To determine if a specific drug is included in this benefit, contact customer service at the toll-free number on your identification card.

Benefits for Organ and Tissue Transplants

a. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

   (1) The transplant procedure is not Experimental/Investigational in nature;
   (2) Donated human organs or tissue or a FDA-approved artificial device are used; and
   (3) The recipient is a Participant under the Plan; and
   (4) The transplant procedure is Prior Authorized as required under the Plan; and
   (5) The Participant meets all of the criteria established by BCBSTX in pertinent written medical policies; and
   (6) the Participant meets all of the protocols established by the Hospital in which the transplant is performed.

   Covered services and supplies "related" to an organ or tissue transplant include, but are not limited to x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

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

   Benefits will be available for:

(1) A recipient who is Covered under this Plan;
(2) A donor who is a Participant under this Plan; or
(3) A donor who is not a Participant under this Plan.

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

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

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

(1) Living and/or travel expenses of the recipient or a live donor;
(2) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
(3) Purchase of the organ or tissue; or
(4) Organ or tissue (xenograft) obtained from another species.

e. Prior Authorization is required for any organ or tissue transplant.

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

f. No benefits are available for any organ or tissue transplant procedure (or the services performed in preparation for, or in conjunction with, such a procedure) which BCBSTX considers to be Experimental/Investigational.

Benefits for Prosthetic Appliances and Orthotic Devices

a. Prosthetic Appliances including replacements necessitated by growth to maturity of the Participant. Prosthetic Appliances and orthotic devices are covered unless the repair or replacement is a result of misuse or loss by you.

b. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed or applied dressings, bandages, trusses and splints that are custom designed for the purpose of assisting the function of a joint.

Benefits for Screening Tests for Hearing Impairment

For a screening test for hearing loss from birth through the date the child is 30 days old; and necessary diagnostic follow-up care related to the screening tests from birth through the date the child is 24 months.

Benefits for Speech and Hearing Services

Benefits are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function. Coverage also includes fitting and dispensing services, the provision of ear molds as necessary to maintain optimal fit of hearing aids and habilitation and Rehabilitation Services.

One cochlear implant, which includes an external speech processor and controller, per impaired ear is covered. Coverage also includes related treatments such as habilitation and Rehabilitation Services, fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids. Implant components may be replaced as Medically Necessary or audiologically necessary. Prior authorization is required.

Benefits for Tests for Detection of Colorectal Cancer
Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer for Participants who are 45 years of age or older and who are at normal risk for developing colon cancer: All colorectal cancer examinations, preventive services, and laboratory test 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 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 a Network Provider will not be subject to Deductible, Copayment Amounts or Coinsurance Amounts.

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

Benefits for Treatment of Acquired Brain Injury
Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment; neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute care treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

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

Service means the work of testing, treatment and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

To ensure that appropriate post-acute care treatment is provided, this Plan includes coverage for expenses related to periodic reevaluation of the care of an individual covered who: (1) Has incurred an Acquired Brain Injury; (2) Has been unresponsive to treatment; and (3) Becomes responsive to treatment at a later date. Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Benefits for Acquired Brain Injury will not be subject to any visit limit.

Benefits for Treatment of Complications of Pregnancy Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as for any other treatment of sickness.

Benefits for Treatment of Diabetes
Benefit are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following:

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Participant.

Covered diabetes equipment is specifically defined as:
a) Blood Glucose monitors, including monitors designed to be used by blind individuals;
b) Insulin infusion devices;
c) Insulin pumps and associated appurtenances; and
d) Infusion sets;
e) Insulin cartridges;
f) Alcohol wipes;
g) Adhesive supplies;
h) Durable and disposable devices to assist in the injection of insulin;
i) Batteries
j) Podiatric appliances (shoes, shoe inserts and foot orthotics) for prevention of complications associated with diabetes.

Diabetic supplies are specifically defined as:
a) Glucose emergency kits;
b) Injection aids;
c) Lancets and lancet devices;
d) Insulin and insulin analogs;
e) Syringes;
f) Prescriptive and nonprescriptive oral agents for controlling blood sugar levels
g) Test strips for blood glucose monitor;
h) Visual reading and urine test strips and tablets which test for glucose, ketone, and protein and
i) Biohazard disposable container.

NOTE (IF YOUR PLAN COVERS PRESCRIPTION DRUGS): Insulin, prescriptive and nonprescriptive oral agents for controlling blood sugar levels, insulin pens and syringes/pen needles are covered under your pharmacy benefits.

Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

As new or improved treatment and monitoring equipment or supplies become available and are approved by the U.S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

Medical-Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self-Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician,

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

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

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

If your Plan includes Maternity Care, it is hereby amended as follows:

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for *Postdelivery Care* for the mother and newborn. The *Postdelivery Care* may be provided at the mother's home, a health care Provider's office, or a health care facility.

Postdelivery Care means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. The term includes:

- parent education,
- assistance and training in breast-feeding and bottle feeding, and
- the performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination and administration of a newborn screening test (which includes the test kit, required by the state of Texas) during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions and benefit maximums as Inpatient Hospital Expenses.

3. If your plan includes prescription drug coverage, that Insurance Contract section hereby amended as follows:

Covered Drugs

1. Benefits for Medically Necessary Covered Drugs prescribed to treat Participant for a chronic, disabling, or life-threatening illness are available under the Plan if the drug: Is included on the applicable Drug List;
2. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
3. Is recognized by the following for treatment of the indication for which the drug is prescribed:
   - a prescription drug reference compendium approved by the Department of Insurance, or
   - substantially accepted peer-reviewed medical literature.

For a list of Covered Drugs, you can access the website at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists or you can also contact customer service at the toll-free number on your Identification Card.

Diabetes Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of Diabetes Supplies for which an authorized Health Care Practitioner has written order. Such Diabetes Supplies, when obtained for a Qualified Participant (for more information regarding Qualified Participant, refer to the Benefits for Treatment of Diabetes section of the medical portion of this Insurance Contract), shall include but not be limited to the following:

- Test strips specified for use with a corresponding blood glucose monitor
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits

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

A separate Copayment Amount and/or Coinsurance Amount will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

Amino Acid-Based Elemental Formulas
Benefits are available for 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.

Prescription Contraceptive Drugs and Devices and Related Services
Benefits are available for contraceptive drugs or devices approved by the United States Food and Drug Administration or an outpatient contraceptive service**.** Deductibles, Copayment Amounts, and Coinsurance Amounts will be the same as any other covered service.

4. Insurance Contract section entitled Limitations and Exclusions is hereby amended as follows:

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

- Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
  a. An inpatient nutritional assessment program provided in and by a Hospital and approved by BCBSTX; or
  c. Benefits for Treatment of Diabetes as described in Special Provisions Expenses; or
  d. Benefits for Children with Developmental Delays as described in Special Provisions Expenses.

- Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

- Disposable or consumable outpatient supplies, such as syringes, needles, blood or urine testing supplies (except as used in the treatment of diabetes); sheaths, bags, elastic garments, stockings and bandages, garter belts, ostomy bags.

- Prosthetic Appliances or orthotic devices not described in Diabetes Care or Prosthetic Appliances and Orthotic Devices including, but not limited to:
  a. orthodontic or other dental appliances or dentures;
  b. splints or bandages provided by a Physician in a non-Hospital setting or purchased over the counter for the support of strains and sprains;
  c. corrective orthopedic shoes, including those which are a separable part of a covered brace; specially ordered, custom-made or built-up shoes and cast shoes; shoe inserts designed to support the arch or affect changes in the foot or foot alignment; arch supports; braces; splints or other foot care items.

- Restoration of loss or correction to an impaired speech or hearing function, except as may be provided under Benefits for Speech and Hearing Services or under Benefits for Hearing Aids.

Changes in 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 Insurance Contract to which this Amendment is attached will remain in full force and effect.

Blue Cross and Blue Shield of Texas

By: James Springfield
President, Blue Cross and Blue Shield of Texas

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 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 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 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 Policy.

Your Policy and any Amendments attached to the Policy are amended as follows:

The ***Your Medical Benefits*** section of Your Policy is amended by deleting the ***Benefits for Mammography Screening*** provision in its entirety and substituting the following revised provision.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Participant 35 years of age and older except that benefits will not be available for more than one routine mammography screening each Calendar Year. Low-dose mammography includes digital mammography or breast tomosynthesis.

The ***Your Medical Benefits*** section of Your Policy is amended by adding the following provisions:

Benefits for Hearing Services

Benefits are available for hearing aids for a Participant 18 years of age or younger. Coverage also includes fitting and dispensing services, the provision of ear molds as necessary to maintain optimal fit of hearing aids and habilitation and rehabilitation services.

Benefits are available one cochlear implant, for a Participant age 18 or younger, which includes an external speech processor and controller, per impaired ear. Coverage also includes related treatments such as habilitation and rehabilitation services, fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids. Implant components may be replaced as Medically Necessary or audiologically necessary.

The ***Special Benefit Provisions*** section of Your Policy is amended by adding the following provisions:

r. Benefits Telehealth and Telemedicine Medical Services

Telehealth and Telemedicine Medical Services are covered, as defined in DEFINITIONS.

The ***Definitions*** section of Your Policy is amended by revising the following definitions:

Telehealth Service means a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

Telemedicine Medical Service means a health care service delivered by a Physician or Behavioral Health Practitioner licensed in Texas, or a health professional acting under the delegation and supervision of a Physician or Behavioral Health Practitioner licensed in Texas, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

The **Your Pharmacy Benefits** section of Your Policy is amended by deleting the **Copayment Amount** provision in its entirety and substituting the following revised provision.

Copayment Amount
If the Allowable Amount of the Covered Drug is less than the Copayment Amount, the Participant will pay the lower cost. When that lower cost is more than the amount you would pay if you purchased the drug without using your BCBSTX pharmacy benefits or any other source of drug benefits or discounts, you pay such purchase price.

The **Pharmacy Benefits** section of Your Policy is amended by adding the following provision:

Prescription Refills
Once every 12 months, you will be able to synchronize the start time of certain Covered Drugs used for treatment and management of a chronic illness so they are refilled on the same schedule for a given time period. When necessary to fill a partial Prescription Order to permit synchronization, BCBSTX will prorate the Copayment Amount or Coinsurance Amount due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply outlined in your Schedule of Coverage.

Refills for prescription eye drops to treat a chronic eye disease or condition will be refilled if (1) the original Prescription Order states that additional quantities of the eye drops are needed; (2) the refill does not exceed the total quantity of dosage units authorized by the prescribing Health Care Practitioner on the original Prescription Order, including refills; and (3) the refill is dispensed on or before the last day of the prescribed dosage period. The refills are allowed;

- not earlier than the 21st day after the date a Prescription Order for a 30-day supply is dispensed;or
- not earlier than the 42nd day after the date a Prescription Order for a 60-day supply is dispensed; or
- not earlier than the 63rd day after the date a Prescription Order for 90-day supply is dispensed.

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

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

Dan McCoy
President 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 **Effective July 15, 2013**

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

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

The **Definitions** section of Your Policy is amended by adding the following to the definition of **Allowable Amount**:

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) - Notwithstanding the above, where applicable state or federal law requires another standard for a non-contracting claim, the Allowable Amount shall be the lessor of billed charge or the amount prescribed by law.

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.

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.

Jeffrey R Tikkanen
President, Retail Markets
Blue Cross and Blue Shield of Texas

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 Benefits Provided section 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.

2. 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:

1. 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.

2. By deleting the Section **Precertification Requirements** in its entirety and replacing it with the following:

Precertification is required for all Hospital Admissions, Extended Care Expense, and Home Infusion Therapy, and organ and tissue transplants.

Precertification establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Contract. It ensures that the precertified care and services as described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. Precertification does not guarantee payment of benefits.

(1) Hospital Admissions

You are required to have Your admission precertified at least two working days prior to actual admission unless it would delay Emergency Care. In an emergency, precertification should take place within two working days after the admission or as soon as reasonably possible.

When a Hospital Admission is precertified, a length-of-stay is assigned. This Contract is required to provide a minimum length of stay in a Hospital for treatment of breast cancer of:

- 48 hours following a mastectomy, and
- 24 hours following a lymph node dissection.

If You require a longer stay than was first precertified, Your Provider may request an extension for the additional inpatient days. If an admission extension is not precertified, benefits may be reduced or denied.

Precertification is also required if You transfer to another facility or to or from a specialty unit within the facility.

If an admission is not precertified, benefits may be reduced or denied if We determine that the admission is not Medically Necessary or is Experimental/Investigational.

Failure to precertify will result in a penalty in the amount of $250 that will be deducted from any benefits which may be finally determined to be available for the Hospital Admission. This penalty amount cannot be used to satisfy Deductibles or to apply toward the Coinsurance Amount. Additionally, We will review the Medical Necessity or Experimental/Investigational nature of Your claim.

(2) Extended Care Expense and Home Infusion Therapy

Precertification is required for Medically Necessary Skilled Nursing Facility services, Home Health Care, Hospice Care or Home Infusion Therapy.

Precertification for Extended Care Expense and Home Infusion Therapy must be obtained by having the agency or facility providing the services submit a treatment plan to Us on a Precertification Review Form. The Precertification Review Form must be completed:

- Before the start of Extended Care Expense or Home Infusion Therapy;
- For periodic recertification of Extended Care Expense or Home Infusion Therapy, and
- When the treatment plan is altered.

If Extended Care Expense or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the precertification telephone number on the back of Your Identification Card.

We will review the information submitted prior to the start of Extended Care Expense or Home Infusion Therapy. A letter will be sent to You and the agency or facility confirming precertification or denying benefits. If Extended Care Expense or Home Infusion Therapy is scheduled to occur within 72 hours, We will notify the agency or facility by telephone. No benefits will be available for charges incurred when the corresponding treatment plan has been previously denied based on the information submitted.

Failure to precertify will result in a penalty in the amount of 50% not to exceed $500 which will be deducted from any benefits which may be finally determined to be available for Extended Care Expense or Home Infusion Therapy.

(3) Organ and Tissue Transplants

Precertification is required for any organ or tissue transplant. Precertification of an organ or tissue transplant is the process by which the Medical Necessity of the transplant and the length of stay of the admission is approved or denied. Precertification does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the precertified length of stay will not be denied on the basis of Medical Necessity or Experimental/Investigational.

At the time of precertification, We will assign a length-of-stay for the admission if We determine that the admission is Medically Necessary. Upon request, the length-of-stay may be extended if We determine that an extension is Medically Necessary.

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.

The General Provisions Section of Your Contract is amended By deleting the Section **Review of Claim Determinations** in its entirety and replacing it with the following:

Review of Claim Determinations:

a. When a claim is submitted properly and received by Us, it will be processed to determine whether and in what amount benefits should be paid. Some claims take longer to process than others do because they require information not provided with the claim. Examples of such matters include determination of Medical Necessity.

   After processing the claim, We will determine and notify the Participant of the exact amount, if any, being paid on the claim; that the claim is being denied in whole or in part and the reason for denial; or that We require additional information before We can determine Our liability. If

additional information is requested, it must be furnished before processing of the claim can be completed.

b. Any Participant (or a parent if he is a minor) has the right to seek and obtain a full and fair review by Us of any determination of a claim, or any other determination made by Us of the Participant's benefits under this Contract.

If a Participant believes We incorrectly denied all or part of his charges and wants to obtain a review of the benefit determination, he must:

(1) Submit a written request for review mailed to Us at Our Administrative Office in Richardson, Dallas County, Texas. The request must state the Participant's full name and Subscriber identification number and the charges on the claim he wants reviewed.
(2) Include in the written request the items of concern regarding Our determination and all additional information (including medical information) that the Participant believes has a bearing on why the determination was incorrect.

On the basis of the information supplied with the request for review, together with any other information available to Us, We will review Our prior determination for correctness and make a new determination. The Participant will be notified in writing of Our decision and the reasons for it within 60 days of Our receipt of the request for review. This determination will be the final internal determination by Us unless additional information, which has not previously been available for review, is provided within 60 days of the Participant's receipt of the determination.

President of Blue Cross and Blue Shield of Texas

An Amendment

Effective July 1, 2007

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

Your Contract is amended as follows:

1. **ARTICLE I - DEFINITIONS** Section of Your Contract is amended by deleting the definition of **Health Status Related Factor** and adding the following new definition:

   Health Status Related Factor means:

   a. Health status;

   b. Medical condition, including both physical and mental illness;

   c. Claims experience;

   d. Receipt of health care;

   e. Medical history;

   f. Genetic information;

   g. Evidence of insurability; and

   h. Disability.

2. **ARTICLE III - PAYMENT OF BENEFITS; PARTICIPANT/PROVIDER RELATIONSHIP** Section of Your Contract is amended by deleting the last item of the **Payment of Benefits** subsection and replacing it with the following new item:

   d. Any benefits payable to You shall, if unpaid at Your death, be paid to Your beneficiary; if there is no beneficiary, then such benefits shall be paid to Your estate.

3. **ARTICLE VI – TERMINATION OF COVERAGE,** Section 1, of Your Contract is amended by deleting the following wording in its entirety:

   On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area for which We are authorized to provide coverage, but only if coverage is not renewed or not continued uniformly without regard to any Health Status Related Factor of covered individuals; or

   and replacing it with the following:

   On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area in which We are authorized to provide coverage, but only if all policies are not renewed or not continued uniformly without regard to any Health-Status Related Factor of covered individuals; or

4. **ARTICLE VI – TERMINATION OF COVERAGE,** Section 2, of Your Contract is amended by deleting the following wording in its entirety:

   On the last day of any Contract Month in which a Dependent no longer resides, lives, or works in an area for which We are authorized to provide coverage, but only if coverage is not renewed or not continued uniformly without regard to any Health Status Related Factor of covered individuals.

   and replacing it with the following:

   On the last day of any Contract Month in which a Dependent no longer resides, lives, or works in an area in which We are authorized to provide coverage, but only if all policies are not renewed or not continued uniformly without regard to any Health-Status Related Factor of covered individuals; or

5. **ARTICLE VII – STANDARD PROVISIONS** of Your Contract is amended by adding the following provision:

   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.

President of Blue Cross Blue Shield of Texas

An Amendment

Effective Date January 1, 2006

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

1. Article IV of this Contract is amended by deleting the section entitled "***Benefits for Preventive Care***" in its entirety and substituting the following:

Benefits for Preventive Care

Medical–Surgical Expense incurred for the following preventive care services will be available under this Contract up to a $300 combined Calendar Year benefit maximum per Participant for Network and Out–of–Network Benefits:

(a) Routine physical examinations,
(b) Well–child care,
(c) Hemoccult tests,
(d) Immunizations for Participants 8 years of age and over,
(e) Routine lab and X–ray, and
(f) Vision and hearing examinations.

Network Benefits will be determined at 100% of the Allowable Amount for Physician office visits and same day diagnostic lab and x–rays. The Copayment Amount will be required.

Out–of–Network Benefits will be determined at 75% of the Allowable Amount for Physician office visits and diagnostic lab and x–rays. The Calendar Year Deductible will be applied.

Benefits are not available for *Inpatient Hospital Expense* or *Medical–Surgical Expense* for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

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

Benefits for routine mammography screening, colorectal cancer screening, prostate cancer screening, and HPV/cervical cancer screening are not available under this preventive care benefit.

2. Article IV of this Contract is amended by adding the following new benefit provision:

Benefits for Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer

If a female Participant 18 years of age or older incurs *Medical–Surgical Expense* for an annual medically recognized diagnostic examination for the early detection of cervical cancer, benefits provided under this Contract shall include:

- A conventional Pap smear screening or a screening using liquid–based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of human Papillomavirus.
- Such screening test must be performed in accordance with the guidelines adopted by:

  (a) The American College of obstetricians and Gynecologists; or
  (b) Another similar national organization of medical professionals.

3. Article V, Section 1, of this Contract is amended by deleting the wording of subsection o in its entirety and substituting the following:

o. Any services or supplies provided in connection with a routine physical examination, diagnostic screening, or immunizations. This exclusion does not apply to the following **except** as may be provided for in the Special Benefit Provisions section in Article IV, of this Contract:

(1) ***Mammography Screening***;

(2) ***Preventive Care*** over and above up to the Calendar Year benefit maximum;

(3) ***Childhood Immunizations;***

(4) ***Certain Tests for the Detection of Prostate Cancer;***

(5) ***Newborn Screening Tests for Hearing Impairment;***

(6) ***Certain Tests for the Detection Colorectal Cancer Screening;***

(7) ***Certain Therapies for Children with Developmental Delays;*** and

(8) ***Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer.***

President of Blue Cross and Blue Shield of Texas

An Amendment

Effective Date January 1, 2004

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

1. Article I, Section 40, of this Contract is amended by deleting the term "Licensed Master Advanced-Clinical Social Worker" and substituting "Licensed Clinical Social Worker."

2. Article IV of this Contract, as previously amended, is amended by deleting the section entitled "***Benefits for Acquired Brain Injury***" in its entirety and substituting the following:

   Benefits for Treatment of Acquired Brain Injury
   Benefits for *Eligible Expenses* incurred for Medically Necessary treatment of Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an Acquired Brain Injury:

   - Cognitive rehabilitation therapy — Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
   - Cognitive communication therapy — Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
   - Neurocognitive therapy and rehabilitation services — (1) Therapy designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities and (2) Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
   - Neurobehavioral treatment —Interventions that focus on behavior and the variables that control behavior.
   - Neurobehavioral testing — An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
   - Neuro-physiological testing — An evaluation of the functions of the nervous system.
   - Neuropsychological testing — The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
   - Neuro-psychological treatment — Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
   - Neuro-physiological treatment — Interventions that focus on the functions of the nervous system.
   - Psychophysiological testing — An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
   - Psychophysiological treatment — Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
   - Neurofeedback therapy — Services that utilizes operant conditioning learning procedure based on electroencephalographs (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

- Remediation — The process(es) of restoring or improving a specific function.
- Post-acute transition services — Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- Community reintegration services — Services that facilitate the continuum of care as an affected individual transitions into the community.

Services means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

3. Article IV, of this Contract is amended by adding the following new benefit provision:

Certain Therapies for Children with Development Delays
Medical-Surgical Expense benefits are provided for a Dependent child under three years of age with *developmental delays* for the necessary rehabilitative and habilitative therapies in accordance with an *individualized family service plan* issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas *Human Resources Code.* Such therapies include:

- Occupational therapy evaluation and services;
- Physical therapy evaluations and services;
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations.

The *individualized family service plan* must be submitted to Us prior to the commencement of services, and when the *individualized family service plan* is altered.

Developmental delays means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Individualized family service plan means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention.

After the age of three, when services under the *individualized family service plan* are completed, Eligible Expenses, as otherwise coverage under this Contract, will be available. All contractual provision of this Contract will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

4. Article V, Section I, of this Contract is amended by deleting the wording of subsections m, o, w, and hh in their entirety and substituting the following:

m. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided in this Contract for:

1. An inpatient nutritional assessment program provided in and by a Hospital and approved by Us;
2. ***Treatment of Diabetes***; and
3. Dietary or nutritional evaluations provided in conjunction with ***Certain Therapies for Children with Developmental Delays***.

o. Any services or supplies provided in connection with a routine physical examination (including a routine Pap smear), diagnostic screening, or immunizations. This exclusion does not apply to the following **except** as provided for in the Special Benefit Provisions section in Article IV, of this Contract for:

1. ***Mammography Screening;***
2. ***Preventive Care*** up to the Calendar Year benefit maximum;
3. ***Childhood Immunizations;***
4. ***Certain Tests for the Detection of Prostate Cancer***,
5. ***Newborn Screening Tests for Hearing Impairment;***
6. ***Certain Tests for the Detection of Colorectal Cancer;*** and
7. ***Certain Therapies for Children with Developmental Delays.***

w. Except as specifically included as an Eligible Expense, any Medical Social Services; any outpatient family counseling and/or therapy bereavement counseling, vocational counseling, Marriage and Family Therapy and/or counseling; any services provided by a Licensed Clinical Social Worker, a Licensed Professional Counselor, or a Marriage and Family Therapist.

hh. Any Speech and Hearing Services. This exclusion does not apply to the following except as provided in the Special Benefit Provisions section of Article IV, Section 1, of this Contract:

(1) *Extended Care Expense*;
(2) ***Preventive Care up*** to the Calendar Year maximum;
(3) ***Newborn Screening Tests for Hearing Impairment***; and
(4) ***Certain Therapies for Children with Developmental Delay***.

President of Blue Cross and Blue Shield of Texas

An Amendment

Effective January 1, 2002

To be attached to and made a part of your Blue Cross and Blue Shield of Texas* PPO Select® Blue Advantage Plan Insurance Contract.

Your Contract is amended as follows:

1. Article I of this Contract is amended by deleting the wording of Section 17 in its entirety and substituting the following:

   17. **Dependent** means:

   a. A Subscriber's spouse; or
   b. Any unmarried child who is under 25 years of age.

   Child means:

   (1) The natural child of the Subscriber; or

   (2) 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); or

   (3) A stepchild; or

   (4) A child for whom the Subscriber has received a court order or an order requiring that Participant have financial responsibility for providing health insurance; or

   (5) A grandchild of the Subscriber who is dependent upon the Subscriber for federal income tax purposes at the time application for coverage is made.

2. Article I, Section 44, of this Contract is by adding the following new subsections:

   Outpatient Contraceptive Services and prescription contraceptive devices. However, coverage for prescription oral contraception medications is provided under the Prescription Drug Program.

   Telehealth Service and Telemedicine Medical Service.

3. Article I, Section 56, of this Contract is amended by adding the following Professional Other Provider:

   Nurse First Assistant

4. Article I of this Contract is amended by adding the following new definitions:

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

   Telehealth Service means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

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

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

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

5. Article IV, Section m, of this Contract is amended by adding the following new subsections:

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of acquired brain injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an acquired brain injury:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neuro-physiological, neuro-psychological, and psychophysiological testing or treatment;
- Neurofeedback therapy;
- Remediation;
- Post-acute transition services; and
- Community reintegration services.

Benefits for Certain Tests for Detection of Colorectal Cancer

If a Participant 50 years of age or older and who is at normal risk for developing colon rectal cancer incurs *Medical-Surgical Expense* for a diagnostic medically recognized screening examination for the detection of colorectal cancer, benefits will be determined as described under Preventive Care, except that if the maximum benefit amount has been reached under that provision:

- Such Participant shall receive benefits for a:

  –Fecal occult blood test performed annually and flexible sigmoidoscopy performed every five years; or
  –Colonoscopy performed every ten years, and

- Benefits will be provided as described in the subsection entitled **Benefits for Medical-Surgical Expense**. The Copayment Amount will be required for Network Benefits for Physician office visits. The Calendar Year Deductible will apply to Out-of-Network Benefits.

6. Article V, Section 1, of this Contract is amended by deleting the wording of subsection o in its entirety and substituting the following:

o. Any services or supplies provided in connection with a routine physical examination (including a routine Pap smear), diagnostic screening, or immunizations. This exclusion does not apply to the following **except** as provided for in the Special Benefit Provisions section in Article IV, of this Contract:

1. Mammography Screening,
2. Preventive Care over and above the Calendar Year benefit maximum,
3. Childhood Immunizations,
4. Certain Tests for the Detection of Prostate Cancer,
5. Screening Tests for Hearing Impairment, and
6. Certain Tests for Detection of Colorectal Cancer.

7. Article V, Section 1, of this Contract is amended by deleting the wording of subsection u in its entirety and substituting the following:

   u. Any services or supplies for mental or nervous disorders. This exclusion does not apply to the following **except** as may be provided in this Contract for Organic Brain Disease as defined in Article I, and acquired brain injury as described Article IV, as amended, in this Contract, as amended.

8. Article V, Section 1, of this Contract is amended by deleting the wording of subsection w in its entirety and substituting the following:

   w. Except as specifically included as an Eligible Expense in this Contract, any Medical Social Services; any outpatient family counseling and/or therapy; bereavement counseling, vocational counseling; or any services or supplies provided by a Licensed Master Social Worker-Advanced Clinical Practitioner, Licensed Professional Counselor, or a Marriage and Family Therapist.

9. Article IV, Section 2, of this Contract, is amended by deleting the wording of subsection b in its entirety and substituting the following:

   b. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar device, artificial appliances, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections). However, coverage for contraceptive devices is provided under the Medical portion of this Contract.

10. Article V, Section 2, of this Contract is amended by deleting the wording of subsection i in its entirety and substituting the following:

    i. Contraceptive devices, non-prescriptive contraceptive materials (**except** oral contraceptive medications which are Legend Drugs), infertility medication and fertility medications. However, coverage for contraceptive devices is provided under the Medical Portion of this Contract.

11. Article VI, Section 2, Subsection a, of this Contract is amended by deleting the wording of paragraph (2) in its entirety and substituting the following:

    (2) Coverage for any unmarried child who is medically certified as Disabled and dependent upon You shall not terminate upon reaching age 25 if the child continues to be both (a) disabled, and (b) dependent upon You for more than one-half of his support as defined by the *Internal Revenue Code* of the United States.

    Disabled mean any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under this Contract and before the child attains age 25. You must submit proof of the disability and dependency to Us within 31 days following the child's attainment of age 25. As a condition to the continued coverage of a child as a disabled Dependent beyond are 25. We may require periodic or mental condition but not more frequently than annually after the two-year period following the child's attainment of age 25.

12. Article VI, of this Contract is amended by deleting the wording of Section 4 in its entirety and substituting the following:

    4. Notwithstanding the provision of Section 2, above, within 30 days of a divorce, marriage of a child, or attaining age 25, the former Dependent losing coverage may elect to apply for coverage in his own name.

    Upon timely application, We will allow coverage under the name of the applicant without evidence of insurability at the then prevailing premium rate for persons of the same age, sex and geographical location.

    In the case of a change in marital status, the new Contract will have the same Effective Date as the Contract under which coverage was afforded prior to the loss of coverage. The rights provided under this Section 4 shall terminate if We do not receive the application within the 30-day period.

13. Article VIII, Section 2, of this Contract is amended by deleting the wording of Subsection b, in its entirety and substituting the following:

    b. As a condition to the continued coverage of a child as a disabled Dependent beyond the age of 25, We shall have the right to require periodic certification of the child's physical or mental condition and dependency, but no more frequently than annually after the two-year period following the child's attainment of age 25.

President

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.

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 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 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.

NOTICE TO BLUE CROSS BLUE SHIELD OF TEXAS CONTRACT HOLDERS

You are hereby notified that you are a member of Health Care Service Corporation, a Mutual Legal Reserve Company, and are entitled to vote either in person, by its designated representative or by proxy at all meetings of members of said company. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

ALLOWABLE AMOUNT NOTICE

IMPORTANT TO YOUR COVERAGE

To pay less out-of-pocket expenses for your health care costs and to receive a higher level of benefits, it is to your advantage to use In-Network Providers. If you use contracting Providers, you will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much you would pay if you use an In-Network Provider and how much you would pay if you use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same (Note: In most cases, however, the non-contracting Allowable Amount will be less than the contracting Allowable Amount, meaning your total payment responsibility will be even greater):

EXAMPLE ONLY

	In-Network 90% of eligible charges $250 Deductible	**Out-of-Network** 80% of eligible charges $500 Deductible
Amount Billed	$20,000	$20,000
Allowable Amount	$5,000	$5,000
Deductible Amount	$250	$500
Plan's Coinsurance Amount	$4,275	$3,600
Your Coinsurance Amount	$475	$900
Non-Contracting Provider's additional charge to you	None	$15,000
YOUR TOTAL PAYMENT	$725 **to a Network Provider**	$16,400 **to a Non-Contracting Out-of-Network Provider**

Even when you consult an In-Network Provider, ask questions about the Providers rendering care to you "behind the scenes." If you are scheduled for surgery, for example, ensure that your Network surgeon will be using a Network facility for your procedure and a Network Provider for your anesthesia services.

If you choose to receive services from an Out-of-Network Provider, inquire if the Provider participates in a contractual arrangement with BCBSTX or any other Blue Cross and/or Blue Shield Plan. Providers who do not contract with BCBSTX may bill the patient for expenses over the Allowable Amount. [1]Refer to PARPLAN in the **HOW THE PLAN WORKS** portion of your booklet for more information.

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.

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'.

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.

BlueCross BlueShield of Texas

HIPAA NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect November 10, 2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or other health care provider providing treatment to you. We may use or disclose your PHI to a health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Health care operations include the business functions conducted by a health insurer. These activities may include providing customer services, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the plan sponsor of a group health plan. We may also in our health care operations disclose PHI to business associates[1] with whom we have written agreements containing terms to protect the privacy of your PHI.

[1] A "business associate" is a person or entity who performs or assists Blue Cross Blue Shield of Texas with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules.

We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing health care fraud and abuse.

Joint Operations: We may use and disclose your PHI connected with a group health plan maintained by your plan sponsor with one or more other group health plans maintained by the same plan sponsor, in order to carry out the payment and health care operations of such an organized health care arrangement.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

Personal Representatives: We will disclose your PHI to your personal representative when the personal representative has been properly designated by you and the existence of your personal representative is documented to us in writing through a written authorization.

Disaster Relief: We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health Related Services: We may use your PHI to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. We may use or disclose your PHI to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA-regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to avert a serious threat to health or safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by and to the extent necessary to comply with state worker's compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization; and
- in connection with certain research activities.

Use and Disclosure of Certain Types of Medical Information: For certain types of PHI we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your PHI:

- *HIV Test Results.* We may not disclose the result of any HIV test unless required by law or the disclosure is to you, your personal representative, a physician or other person who ordered the test, or a health care worker who has a legitimate need to know the results of the test for safety purposes; or pursuant to an authorization signed by you providing us permission to disclose to an insurance medical

information exchange, a reinsurer, or to our attorneys.

- *Genetic Information.* If any genetic test information is included in claims or records we receive, we may not use or disclose your genetic information unless the use or disclosure is authorized by law or you provide us with written permission to disclose such information.
- *Status as Victim of Family Violence.* We may not disclose your status as a victim of family violence unless the disclosure is to you; to a physician or health care provider for the provision of health care services; to a licensed physician designated by you; as required by law or pursuant to an order of the Texas Insurance Commissioner or a court order; to our attorneys; or when necessary for our payment and health care operations if to a reinsurer, a party to a sale of all or part of our business or to medical and claims personnel we contract with, providing we cannot without undue hardship first segregate the medical information in a way that does not disclose your status as a victim of family violence.
- *Mental Health Information.* We may not disclose your mental health information except for the same purposes for which we received the information or as may be required by law.
- *Confidential Communications from a Physician.* We may not disclose confidential information about you that we receive from a physician for any purpose other than for which we received the information or as may be required by law.
- *Medical Information We Receive While Performing Utilization Review.* If we collect or receive your medical information while performing utilization review activities, we may not disclose that information unless the disclosure is required by law or to an individual or entity that we have contracted with to aide us in performing utilization review.

Individual Rights

You may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

Access: You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. A "designated record set" contains records we maintain such as enrollment, claims processing, and case management records. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so**.** You must make a request in writing to obtain access to your PHI and may obtain a request form from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Disclosure Accounting: You have the right to receive a list of instances for the 6-year period, but not before April 14, 2003 in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, health care operations, or as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fee structure at your request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your

request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting the Privacy Office or by using our website, **www.bcbstx.com**. If you receive this notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, you may complain to using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services; see information at its website: www.hhs.gov. If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Director, Privacy Office
Blue Cross Blue Shield of Texas
P.O. Box 804836
Chicago, IL 60680-4110

You may also contact us using the toll-free number located on the back of your BCBSTX's member identification card.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

Form Number NTC-1731-0907 Stock Number 43984.0907

NOTICE TO BLUE CROSS AND BLUE SHIELD OF TEXAS CONTRACTHOLDER

BlueCard

Like all Blue Cross and Blue Shield Licensees, the Plan participates in a program called "BlueCard." Whenever Participants access health care services outside the Plan's service area, the claims for those services may be processed through BlueCard and presented to the Plan for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Participants receive covered services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), the Plan will remain responsible to the Contractholder for fulfilling the Plan's contract obligations.

However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers, handling all interaction with its participating Providers. The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

The calculation of the Participant's liability on claims for covered services incurred outside the Plan's service area and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price the Plan pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by the Plan on a claim for health care services processed through BlueCard may represent:

(i) The actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"), or

(ii) An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or

(iii) An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Participant and the Contractholder from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or an Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over– or underestimation of past prices. However, the amount paid by the Participant is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating the Participant's liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate the Participant's liability for any covered services consistent with the applicable state statute in effect at the time the Participant received those covered services.

Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.