Your **Contract**

Select 2000SM

INDIVIDUAL HEALTH COVERAGE

BlueCross BlueShield of Texas*

Keeping Texans in a Healthy State

www.bcbstx.com

0009.036-898

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 the Subscriber, 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 the Carrier

Administrative Office: Richardson, Dallas County, Texas

Has issued this individual

Select 2000SM Plan 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, the Carrier agrees 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.

Roger K Coleman
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 WORKER'S 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.

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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 decided by the Carrier to be eligible for consideration of payment for a particular service, supply or procedure.

   For Providers contracting with BCBSTX, Allowable Amount is based on the terms of the contract and BCBSTX payment methodology in effect on the date of service. The payment methodology used may include diagnosis related groups (DRG), relative value, resource based relative value scale (RBRVS), fee schedule, package pricing, global pricing, or other payment methodologies.

   a. For Hospitals and Facility Other Providers not contracting with BCBSTX, no payment will be made by BCBTX.

   b. For procedures, services or supplies provided in Texas by Physicians and Professional Other Providers not contracting with BCBSTX, Allowable Amount shall be the lesser of the billed charge or the amount BCBSTX 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 in the same locale, as determined by BCBSTX from data it has compiled.

      If BCBSTX does not have sufficient data to calculate the Allowable Amount for a particular procedure, service or supply, BCBSTX 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 its attention, which require additional experience, skill and/or time.

   c. For procedures, services or supplies performed outside Texas by Physicians or Professional Other Providers not contracting with BCBSTX or any other Blue Cross and Blue Shield Plan, BCBSTX will establish an Allowable Amount using, at its option, Dallas County or Texas statewide profiles of charges applicable to procedures, services or supplies of Physicians or Professional Other Providers with similar skills and experience.

   d. For multiple surgeries, if there is not a unique Allowable Amount for multiple surgeries done through the same incision or in the same operative area, the Allowable Amount for all procedures combined 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.

   e. 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 markup. AWP means the average wholesale price of a drug on the date the drug is administered by the Home Infusion Therapy Provider. The AWP is taken from nationally recognized sources in current use.

   f. For services, supplies or procedures provided to Medicare recipients, the Allowable Amount will not exceed Medicare's limiting charge.

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

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

5. **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).

6. **Coinsurance Amount** means a dollar amount of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under this Contract. Such Eligible Expenses do not include:

   a. The penalty amount if precertification is not obtained, or the Deductible;

   b. Services, supplies, and charges limited or excluded by this Contract; or

   c. Expenses not covered because a benefit maximum has been paid.

7. **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 non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

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

9. **Contracting Facility** means a Hospital, a Facility Other Provider, or any other facility or institution with which the Carrier has executed a written contract pursuant to Article 20.11, *Texas Insurance Code,* for the provision of care, services, or supplies furnished within the scope of its license for benefits available under this Contact. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in this Contract shall be deemed a Noncontracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

10. **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.

11. **Covered Oral Surgery** means maxillofacial surgical procedures limited to:

a. Excision of non-dental 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, Section 15, of this Contract.

12. **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:

- Accident only, disability income insurance, or a combination thereof;
- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' Compensation or similar insurance;
- Credit-only insurance;
- Coverage for onsite medical clinics;
- Coverage for limited-scope dental or vision benefits;
- Long-term care, nursing home care, home health care, or community-based care coverage or benefits, or any combination thereof;
- Coverage for a specified disease or illness;
- Hospital indemnity or other fixed indemnity insurance; or

- 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;
- Other similar coverage specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits; and
- Automobile payment insurance.

13. **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.

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

15. **Dependent** means:

a. The Subscriber's spouse; or

b. An unmarried child who is under 23 years of age.

Child means:

- The natural child of the Subscriber; 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); or
- A stepchild of the Subscriber whose primary residence is the Subscriber's household; or
- 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
- A grandchild of the Subscriber who is dependent upon the Subscriber for Federal income tax purposes.

16. **Diabetic Equipment and Supplies** means those items of *Medical-Surgical Expense* associated with the treatment of diabetes. Such items, when obtained for a ***qualified participant***, shall include the following:

a. Diabetic Equipment

- Blood glucose monitors (including monitors for the blind),
- Insulin pumps and necessary accessories,
- Insulin infusion devices, and
- Podiatric appliances for the prevention of complications associated with diabetes.

b. Diabetic Supplies

- Test strips for blood glucose monitors,
- Visual reading and urine test strips,
- Lancets and lancet devices,
- Insulin and insulin analogs,
- Injection aids,
- Syringes,
- Prescriptive and non-prescriptive oral agents for

controlling blood sugar levels, and

- Glucagon emergency kits.

Injectable insulin shall be limited to no more than four 10cc vials on any occasion when the insulin is dispensed. The quantity of disposable syringes and needles covered for self-administered injections shall be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles on any occasion dispensed.

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.

17. **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.

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

19. **Eligible Expenses** means either *Inpatient Hospital Expense, Medical-Surgical Expense,* or *Extended Care Expense*, all as specified in this Contract.

20. **Emergency Care** means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

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

    b. Serious impairment to bodily functions; or

    c. Serious dysfunction of any bodily organ.

    Benefits for Emergency Care will be determined on the same basis as for any other sickness.

21. **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 non-organic, non-repetitive diet techniques.

22. **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.

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

Although a Physician or Professional Other Provider may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, the Carrier 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.

23. **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.

24. **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.

25. **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.

26. **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.

27. **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.

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

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

    a. Licensed in accordance with state law (where the state law provides for such licensing); and

    b. Certified by Medicare as a supplier of Hospice Care.

30. **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.

31. **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, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations, 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, place for the treatment of alcohol abuse or drug abuse, or a Hospice.

32. **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, the Carrier 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.

33. **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.

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

35. **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 Member Hospital or Nonmember Hospital (for Nonmember Hospitals such charges must be allowable as determined by the Carrier; and

c. Furnished to and used by the Participant during a Hospital Admission.

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

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

36. **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.

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

38. **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.

39. **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, and in the case of a Licensed Dietitian, Licensed Master Social Worker-Advanced Clinical Practitioner, Licensed Professional Counselor, or a Licensed Marriage

and Family Therapist, a professional recommendation has been obtained from a Physician.

b. Services of a certified registered nurse-anesthetist.

c. Physical Medicine Services up to a maximum benefit of $500 per Participant each Calendar Year.

d. Diagnostic x-ray and laboratory procedures.

e. Radiation therapy.

f. Drugs and medicines, including injectable, drugs purchased for use outside of a Hospital which require a written prescription for purchase in those limited quantities required for the immediate therapeutic needs of the Participant while covered under this Contract (not including Home Infusion Therapy items) up to a maximum benefit amount of $1,000 per Participant each Calendar Year.

g. Benefits for charges deemed to be in excess of the Participant's own immediate therapeutic needs may be denied, or if already paid, will be recoverable upon later review.

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

i. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Carrier. The term durable medical equipment shall not include:

- Equipment primarily designed for alleviation of pain or provision of patient comfort; or
- Home air-fluidized bed therapy.

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

j. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition up to a maximum benefit amount of $1,000 per Participant each Calendar Year.

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

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

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

n. Prosthetic Appliances required for the alleviation or correction of conditions arising out of Accidental Injury occurring or sickness commencing after the Participant's effective date of coverage hereunder, excluding all replacements of such devices other than those necessitated by growth to maturity of the Participant.

o. 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.

p. 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.

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

r. Diabetic Equipment and Supplies, including but not limited to, prescription orders for insulin, insulin analogs, prescriptive and non-prescriptive oral agents for controlling blood sugar levels.

40. **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.

The medical staff of the Carrier shall 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.

41. **Member Hospital** means any Hospital located in the State of Texas which is a Contracting Facility and which has executed a written Member Hospital Contract with the Carrier pursuant to Article 20.11, *Texas Insurance Code*, for the provision of certain categories of care, services, and supplies for which benefits are provided under this Contract.

42. **Noncontracting Facility** means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with the Carrier pursuant to Article 20.11 *Texas Insurance Code*, for the provision of care, services, or supplies for which benefits are provided by this Contract. Any Hospital, Facility Other Provider, facility, or institution with a written contract with the Carrier which has expired or has been canceled is a Noncontracting Facility.

43. **Nonmember Hospital** means any Hospital located in the State of Texas which is a Contacting Facility and has executed a written Nonmember Hospital Contract with the Carrier pursuant to Article 20.11, *Texas Insurance Code*, for the provision of certain categories of care, services or supplies for which benefits are provided by this Contract.

44. **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.

45. **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:

- Durable Medical Equipment Provider
- Home Health Agency
- Home Infusion Therapy Provider
- Hospice
- Imaging Center
- Independent Laboratory
- Prosthetic/Orthotics Provider
- Renal Dialysis Center
- Skilled Nursing Facility
- 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:

- Advanced Practice Nurse
- Doctor of Chiropractic
- Doctor of Dentistry
- Doctor of Optometry
- Doctor of Podiatry
- Doctor in Psychology
- Licensed Audiologist
- Licensed Dietitian
- Licensed Hearing Aid Fitter and Dispenser
- Licensed Marriage and Family Therapist
- Licensed Master Social Worker-Advanced Clinical Practitioner
- Licensed Professional Counselor
- Licensed Occupational Therapist
- Licensed Physical Therapist
- Licensed Speech-Language Pathologist
- 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.

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

47. **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.

48. **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*.

49. **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.

50. **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.

51. **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.*

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

53. **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.

54. **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.

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

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

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

56. **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.

57. **Subscriber** means the person named on the identification card enclosed with this Contract.

58. **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.

59. **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 the Subscriber's natural child born after the Subscriber's 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, the Subscriber must notify the Carrier within 31 days of the birth and pay the required premium within the first 31 days following the date of birth. If the Subscriber wait until after this 31-day period to add the child, coverage shall be contingent upon the Subscriber making application for such coverage on a form approved by Us.

The application form and satisfactory evidence of insurability must be submitted to the Carrier at its Administrative Office. Subject to the Carrier's 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 the Carrier approves the application.

2. **Court Ordered Coverage for Dependents**

If the Subscriber is 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, the Subscriber must make application for coverage on a form approved by the Carrier and pay the required premium within that 31-day period. If the Carrier receives notification after the 31-day period, coverage shall be contingent upon the Subscriber's making application for such coverage on a form approved by the Carrier. The application form and satisfactory evidence of insurability must be submitted to the Carrier at its Administrative Office. Subject to the Carrier's approval of the application, evidence of insurability, and payment of the first full month's premium, coverage shall become effective of the first day of the Contract Month following the date the Carrier approves the application.

3. **Other Dependents**

Coverage for a Dependent (other than a newborn child or court ordered child) shall be contingent upon the Subscriber making application for such coverage on a form approved by the Carrier. The application form must be submitted to the Carrier at its Administrative Office. Subject to the Carrier's 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.

Coverage for a Dependent (other than a newborn child or a court ordered child) of a Subscriber already having coverage under this Contract shall be contingent upon the Subscriber making application for such coverage on a form approved by the Carrier. The application form and satisfactory evidence of insurability must be submitted to the Carrier at its Administrative Office. Subject to the Carrier's 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 the Carrier approves the application.

Article III – Payment of Benefits; Participant/ Provider Relationship

1. **Payment of Benefits**

Payment of benefits by the Carrier to the Provider furnishing the service or to the Subscriber, as the Carrier may elect, shall constitute full discharge of all responsibility of the Carrier to the Subscriber on account of benefits available to any Participant under this Contract.

The rights and benefits of this Contract shall not be assignable, either before or after services and supplies are provided.

It is understood and agreed that the allowances described in Article IV for services and supplies furnished by a Provider whom the Carrier does 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.

Any benefits payable to the Subscriber shall, if unpaid at the Subscriber's death, be paid to the Subscriber's surviving spouse, as beneficiary; if there is no surviving spouse, then such benefits shall be paid to the Subscriber's estate.

2. **Participant/Provider Relationship**

The choice of a health care Provider is made solely by the Participants. The Carrier does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Carrier is not liable for any act or omission by any health care Provider. The Carrier does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to a Participant.

Article IV – Benefits Provided

Subject to the conditions and Limitations and Exclusions in this Contract, when any Participant while covered under this Contract incurs Eligible Expenses, benefits shall be determined as follows:

1. **Medical Necessity**

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

2. **ParPlan Providers**

When You consult a Physician or Professional Other Provider, You should inquire if he participates in the Carrier's *ParPlan*...a simple direct-payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan*, he agrees to:

a. File all claims for You,

b. Accept the Carrier's Allowable Amount determination as payment for Medically Necessary services, and

c. Not bill You for services over the Allowable Amount determination.

You will be responsible for any applicable Deductibles and Coinsurance Amounts, 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 charges above the Carrier's Allowable Amount determination.

3. **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.

a. **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. If the Participant requires a longer stay than was first precertified, the

Participant's Provider may request an extension for the additional days. If an admission extension is not precertified, benefits may be reduced or denied.

Precertification is also required if the Participant transfers 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 Amount. Additionally, We will review the Medical Necessity of the Participant's claim.

b. **Extended Care Expense and Home Infusion Therapy**

Extended Care Expense and Home Infusion Therapy ***are not*** available without precertification, Inpatient precertification of a Hospital Admission does not include precertification of *Extended Care Expense* or Home Infusion Therapy.

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

Precertification must be obtained by having the agency or facility providing the services submit a treatment plan to the Carrier on a Precertification Review Form. The Precertification Review Form must be completed:

- Before the start of *Extended Care Expense* or Home Infusion Therapy;
- Every 30 days for recertification of Extended Care Expense or Home Infusion Therapy, or
- 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.

The Carrier 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 indicating whether benefits for the treatment plan requested are available. 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.**

c. **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, the Carrier will assign a length-of-stay for the admission if it determines that the admission is Medically Necessary. Upon request, the length-of-stay may be extended if the Carrier determines that an extension is Medically Necessary.

4. **Deductibles**

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

When the total amount of the Deductible incurred in a Calendar Year by Participants under the Subscriber's coverage equals three times the Deductible amount indicated in the Subscriber's application for this Contract, all such Participants will have satisfied their Deductible for the remainder of that Calendar Year.

No Participant will be required to contribute more than the individual Deductible amount to the family Deductible amount.

5. **Coinsurance Stop-Loss**

When a Participant's Coinsurance Amount for a Calendar Year under this Article IV equals $2,000, the benefit percentage of 80% shall automatically become 100% for purposes of determining the benefits available for all additional Eligible Expenses incurred by such Participant for the remainder of the Calendar Year involved.

6. **Maximum Lifetime Benefits**

The total amount of benefits available to any one Participant under this Contract shall not exceed $1,000,000. This maximum lifetime benefits amount includes all payments made under any provision of Article IV of this Contract.

7. **Benefits for Inpatient Hospital Expense**

If *Inpatient Hospital Expense* is incurred during each Hospital Admission in excess of the Deductible specified above, the Carrier will provide benefits at 80% of the Allowable Amount. The remaining unpaid *Inpatient Hospital Expense* in excess of the Deductible will be applied to the Coinsurance Amount.

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

If *Medical-Surgical Expense* is incurred in excess of the applicable Deductible, benefits will be reimbursed at 80% of the Allowable Amount. The remaining unpaid *Medical-Surgical Expense* in excess of the Deductible will be applied to the Coinsurance Amount.

9. **Benefits for Extended Care Expense**

As explained previously, all *Extended Care Expenses* requires precertification. *No benefits are available unless the treatment plan is precertified.* When *Extended Care Expense* is precertified, the Carrier will provide benefits at 100% of the Allowable Amount, up to the amount of the combined benefit maximums shown below for each category of *Extended Care Expense*. The Deductible will not be applicable 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*:

a. For Skilled Nursing Facility *–Calendar Year maximum benefit –$5,000 per Participant*

- All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
- Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;

- Physical, occupational, speech, and respiratory therapy services by licensed therapists.

b. For Home Health Care – *Calendar Year maximum benefit – $5,000 per Participant*

- Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
- Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- Physical, occupational, speech, and respiratory therapy services by licensed therapists;
- Supplies and equipment routinely provided by the Home Health Agency.

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

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

c. Hospice Care – *Lifetime maximum benefit – $10,000 for each Participant*

- For Home Hospice Care:

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, speech, and respiratory therapy services by licensed therapists;

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

- For Facility Hospice Care:

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 Hospice facility;

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

10. **Case Management**

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

Under certain circumstances, the Carrier may offer benefits for expenses which are not otherwise Eligible Expenses. The Carrier, at its sole discretion, may offer such benefits if the:

a. Participant, his family, and the Physician agree; and

b. Benefits are cost effective; and

c. The Carrier anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

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

11. **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.

a. **Benefits for Treatment of Complications of Pregnancy**

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

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

b. **Benefits for Mammography Screening**

If a female Participant 35 years of age or older incurs *Medical-Surgical Expense* for a screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as other *Medical-Surgical Expense*, except that benefits will not be available for more than one mammography screening each Calendar Year. The Deductible will apply.

c. **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:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant while covered under this Contract;
- Treatment provided for reconstructive surgery following surgery while the Participant was covered under this Contract;
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
- Surgery performed on a Dependent child, other than a

newborn child, under the age of 19 for treatment or correction of a congenital defect other than conditions of the breast.

- Surgical reconstruction of a breast on which mastectomy surgery has:

  (a) Been performed; and
  (b) **Not** been performed.

  Surgical breast reconstruction means the services or supplies necessary to rebuild the breast and achieve reasonable breast symmetry.

d. **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 on the same basis as for any other sickness. Benefits will be provided only 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 the Plan 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.

e. **Benefits for Dental Services**

- 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:

  a. Covered Oral Surgery; or

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

  c. 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:

     i) For 24 months from the date of accident; or
     ii) 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.

- Except as excluded in Article V 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.**

f. **Benefits for Well-Child Care**

If a Dependent child through age seven incurs *Medical-Surgical Expense* for ***Well-Child Care***, benefits shall be provided on the same basis as for any other sickness.

Well-Child Care means a program of periodic physical examination and developmental assessment for a child through age seven.

g. **Benefits for Childhood Immunizations**

Benefits for *Medical-Surgical Expense* incurred by a Dependent child through age seven for childhood immunizations will be determined at 100% of the Allowable Amount. The Deductible and Coinsurance Amount will not apply. Benefits are available for:

- Diphtheria,
- Haemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella; and
- Any other immunization that is required by law for the child.

Allergy injections are not considered immunizations under this benefit provision.

h. **Benefits for Organ and Tissue Transplants**

When a transplant procedure is needed, have Your Physician or Professional Other Provider contact the Carrier's transplant coordinator in its Case Management department. The Carrier's transplant coordinator may be able to arrange for benefits not otherwise provided under this Contract for transplants received in selected transplant Hospitals. Selected trans-plant Hospitals are noted for their success rate with particular transplant procedures.

Please be advised You can only access the selected transplant Hospitals through the Carrier's transplant coordinator with the Case Management program. Services provided before admission to and after discharge from a selected transplant Hospital will be subject to the benefits described in this Contract.

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.

- Subject to the conditions described below, including the organ and tissue transplant maximum, 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:

(a) The transplant procedure is not Experimental/Investiga-tional in nature;

(b) Donated human organs or tissue are used;

(c) 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;

(d) The transplant procedure is precertified as provided in Section 3, Subsection c, of this Article IV;

(e) The Participant meets all of the criteria established by the Carrier in its written medical policy guide-lines; and

(f) The Participant meets all of the protocols established by the Hospital in which the transplant is per-formed.

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

(a) Liver;
(b) Heart;
(c) Heart-Lung (heart and one lung or heart and two lungs);
(d) Kidney;
(e) Cornea;
(f) Lung;
(g) Bone Marrow.

- Covered services and supplies include services and supplies provided:

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

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

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

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

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

(b) Donor search and acceptability testing of potential living donors;

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

(d) Purchase of the organ or tissue.

- 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 the Carrier considers to be Experimental/ Investigational.
- The total amount of benefits for organ and tissue transplants available to any one Participant under this Contract shall not exceed a $100,000 maximum. This maximum shall include benefits provided for prescription drugs used while in the Hospital. Benefits provided for drugs used on an outpatient basis will be applied to the Calendar Year maximum benefit amount specified in Article I, Section 39f, of this Contract.

Article V – Limitations and Exclusions

The benefits as described in Article IV of this Contract are not available for:

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

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

3. Any services or supplies for which benefits are, or could upon proper claims be, provided under the Worker's 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 are not limited to, any services or supplies for which benefits are payable under Part A or 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 3 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.

4. Any charges for services and supplies provided which requires the Carrier's approval when approval is not given.

5. 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).

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

7. Any services or supplies provided for injuries sustained:

   a. As a result of war, declared or undeclared, or any act of war; or

   b. While on active or reserve duty in the armed forces of any country or international authority.

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

9. Any charges:

a. Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or

b. For completion of any insurance forms; or

c. For acquisition of medical records.

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

11. Any services or supplies furnished by a Noncontracting Facility (except that in accident cases, the immediate, initial treatment necessary to stabilize the Participant furnished by any Hospital, including a governmental facility, shall be subject to benefits as provided in Article IV of this Contract); or any services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with the Carrier.

12. 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 provided in Article VI, Section 1, Subsection g, of this Contract.

13. 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 the Carrier.

14. Any services or supplies for Custodial Care.

15. 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:

a. Mammography screening,

b. Well-Child Care,

c. Childhood immunizations, or

d. Certain tests for the detection of prostate cancer as provided in this Contract.

16. 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, or 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.

17. 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.

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

19. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in Article IV of this Contract.

20. Any services or supplies provided for:

a. Treatment of myopia and other errors of refraction, including refractive surgery; or

b. Orthoptics or visual training; or

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

d. Examinations for the prescription or fitting of eyeglasses, contact lenses or hearing aids, except as may be provided in Article IV of this Contract.

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

22. Any services or supplies provided in conjunction with hearing aids.

23. Any Medical Social Services (except as 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.

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

25. 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.

26. 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.

27. 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.

28. 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.

29. Any services or supplies provided primarily for:

a. Environmental Sensitivity; or

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

c. Inpatient allergy testing or treatment.

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

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

a. Sterilization reversal (male or female);

b. Transsexual surgery;

c. Sexual dysfunction;

d. In vitro fertilization services; and

e. Promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination super ovulation uterine capaciation enhancement, direct-intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

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

a. 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

b. Any services performed in the absence of localized illness, injury, or symptoms involving the foot; and

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

- Clinical evidence of mycosis of the toenail;
- Compelling medical evidence documenting that the patient either:
  - (a) Has a marked limitation of ambulation requiring active treatment of the foot; or
  - (b) 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
  - (c) Excision of a nail with-out using an injectable or general anesthetic.

33. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations; or any Retin-A or pharmacologically similar topical drugs for Participants age 25 and older.

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

35. Any Speech and Hearing Services except for:

a. *Extended Care Expense*; and

b. Well-Child Care as provided in Article IV of this Contract.

36. 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:

a. 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

b. 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 he does not have aggregate Creditable Coverage totaling 18 months, the Carrier 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.

37. Any services or supplies for reduction mammoplasty.

38. Any smoking cessation prescription drug products, including, but not limited to, nicotine gum or nicotine patches.

39. Any services or supplies provided for the following treatment modalities:

a. Acupuncture;

b. Video-fluoroscopy;

c. Intersegmental traction;

d. Surface EMGs;

e. Manipulation under anesthesia; and

f. Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

40. Any 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.

41. Any services or supplies provided for or in conjunction with a condition which has been specifically excluded in the Subscriber's application attached to and made a Part of this Contract.

42. Any services or supplies not specifically defined as an Eligible Expense under 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 the Carrier, 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 the Carrier 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 reside, live, or work in an area for which the Carrier is 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 the Carrier to the Subscriber, but only if it is terminating all other Form No. SEL-5 Plan Contracts; provided that the Carrier offers 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 f, 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:

- The duration of the policy benefit period; or
- Payment of maximum benefits under this Contract; or
- A period of not less than 90 days.

Total Disability, for purposes of this subsection f, 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. The Carrier may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if it:

- Notifies 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;
- Notifies each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and
- Acts uniformly without regard to any Health Status Related Factor 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 15, of this Contract, provided that:

- If such date falls within a period for which the Carrier has accepted premium, coverage shall not terminate until the last day of such period; or
- Coverage for any unmarried child who is medically certified as Disabled and dependent upon the Subscriber shall not terminate upon reaching age 23 if the child continues to be both: (a) Disabled, and (b) dependent upon the Subscriber 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. The Subscriber must submit satisfactory proof of the disability and dependency to the Carrier 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, the Carrier 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 the Carrier prior thereto; or

d. On the last day of any Contract Month in which a Dependent no longer reside, live, or work in an area for which the Carrier is 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 the Carrier 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, the Carrier 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 no application is received by the Carrier within the 30-day period.

Article VII – Standard Provisions

1. **Claim Forms:** The Carrier will furnish to the Sub-scriber, the Hospital, and/or the Participant's Physician or Professional Other Provider, upon receipt of a notice of claim or prior thereto, such forms as are usually furnish by it for filing Proof of Loss. If such forms are not furnished within 15 days after receipt of such notice by the Carrier, 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 the President, Vice President, Secretary, or an Assistant Secretary of the Carrier 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. The Carrier 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: (1) ten days for monthly, or (2) 30 days for quarterly, semi-annual and annual 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 the Carrier will be paid the premium rate at the true age of the Participant.

6. **Notice of Claim** The Subscriber shall give or cause to be given written notice to the Administrative Office of the Carrier at Richardson, Dallas County, Texas or its 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:** The Carrier, at its 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 the Carrier 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 Contracting Facility, written Proof of Loss must be furnished to the Administrative Office of the Carrier at Richardson, Dallas County, Texas, or its 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 Contracting Facility must be furnished to the Carrier by the Contracting Facility in strict compliance with the written contract between the Carrier or another Blue Cross Plan and the Contracting Facility. 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 the Carrier or any of its 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 the Carrier 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:** The Carrier shall 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 the Carrier having waived physical examination in connection with the application, the Subscriber, on behalf of himself and his covered Dependents, shall be deemed to have authorized any attending Physician, Other Provider or Hospital to furnish the Carrier 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, the Carrier 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:** The Subscriber understands that this Contract constitutes a contract solely between the Subscriber and Blue Cross and Blue Shield of Texas (BCBCTX). Blue Cross and Blue Shield of Texas is a Division of Health Care Service Corporation, an Independent Licensee of the Blue Cross and Blue Shield Association (the 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. Blue Cross and Blue Shield of Texas is not contracting as the agent of the Association. The Subscriber also understands that he has not entered into this Policy based upon representations by any person other than Blue Cross and Blue Shield of Texas. No person, entity, or organization

other than Blue Cross and Blue Shield of Texas shall be held accountable or liable to the Subscriber for any of its obligations created under this Policy. This Section 4 shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Texas other than those obligations created under other provisions of this Policy.

5. **Premiums:**

a. The premium applicable to this Contract is determined by the Subscriber, his age, his place of residence on each premium due date, whether or not a Participant is a user of tobacco products, and the number and classification of the family members covered hereunder in accordance with the schedules filed with the Texas Department of Insurance.

The Subscriber shall notify the Carrier in writing of any change in his place of residence within 30 days of the date of change.

The Subscriber place of residence means the address where he principally resides and regularly maintains physical presence.

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

- **Change in Premium Upon Notice:** The Carrier reserves the right to adjust the premium upon 30 days notice to the Subscriber. 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.
- **Change of Residence:** If the Subscriber changes his 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 change in residence; provided that if such change is to a lower premium rate and the Subscriber fails to notify the Carrier in writing of such change prior to the date of change, the Subscriber's right to refund of overpayment shall be limited to the overpayment for the six months immediately preceding the date of notification to the Carrier.
- **Age:** If the Subscriber attains 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 his birthday.

6. **Refund of Benefit Payments:** If and when the Carrier determines that benefit payments hereunder have been made erroneously but in good faith, the Carrier reserves 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. The Carrier reserves 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 the Carrier, it will be processed to determine whether and in what amount benefits should be paid. Some claims take longer to process than others because they require information not provided with the claim. Examples of such matters include determination of Medical Necessity and Preexisting Conditions.

After processing the claim, the Carrier 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 the Carrier requires additional information before it can determine its 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 the Carrier of any determination of a claim, or any other determination made by the Carrier of the Participant's benefits under this Contract.

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

- Submit a written request for review mailed to the Administrative Office of the Carrier 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.
- Include in the written request the items of concern regarding the Carrier's determination and all additional information (including medical information) 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 the Carrier, the Carrier will review its prior determination for correctness and make a new determination. The Participant will be notified in writing of the Carrier's decision and the reasons for it within 60 days of the Carrier's receipt of the request for review. This determination will be final unless additional information which has not been previously 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:

- The Texas Department of Human Services is paying benefits pursuant to Chapter 31 or 32 of the Human Resources Code; and
- 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
- The Carrier receives written notice at its 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 the Carrier pays or provides benefits for You or Your Dependents under this Plan, the Carrier is subrogated to all rights of recovery which the You or Your Dependents have in contract, tort or otherwise against any person, organization or insurer for the amount of benefits the Carrier has paid or provided. That means the Carrier may use the 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 (the Carrier) in the place of another (You or Your Dependents) 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, the Carrier will have a right of reimbursement.

If You or Your Dependents recover money from any person, organization or insurer for an injury or condition for which the Carrier paid benefits under this Plan, You or Your Dependents agree to reimburse the Carrier from the recovered money for the amount of benefits paid or provided by the Carrier. That means You or Your Dependents will pay to the Carrier the amount of money You recover through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Carrier.

Right to Recovery by Subrogation or Reimbursement

You or Your Dependents agree to promptly furnish to the Carrier all information which You have concerning Your rights of recovery from any person, organization or insurer and to fully assist and cooperate with the Carrier in protecting and obtaining its reimbursement and subrogation rights. You, Your Dependents or the Your attorney will notify the Carrier 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 Dependents further agree not to allow the reimbursement and subrogation rights of the Carrier to be limited or harmed by any acts or failure to act on Your part.

Notices

NOTICE OF ANNUAL MEETING

You are hereby notified that you are a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and you are entitled to vote in person, or by proxy, at all meetings of Health Care Service Corporation. The annual meeting is held at our principal office at 300 East Randolf, Chicago, Illinois at 12:30 p.m. on the last Tuesday in October.

ANNUAL MEETING

IMPORTANT MEMBER NOTIFICATION

As a subscriber of Blue Cross and Blue Shield of Texas, Inc. * (BCBSTX), you and your eligible dependents now have access to BlueCard PPO – a program designed to provide easy access to PPO network providers and hospitals while traveling in almost any region of the United States. 1

PPO SUBSCRIBERS

Prior to seeking medical services, select a PPO provider from the network provider directory supplied to you. You will then be eligible to receive the in-network level of benefits provided by your health plan when a network provider renders care. Always visit BCBS PPO network providers (even while traveling outside your local plan service area) and you will receive the in-network benefits available through your health plan.

Although network providers (outside of Texas) may precertify those services requiring precertification, it is ultimately your responsibility to obtain precertification by calling the appropriate number on the back of your ID card. You will also be responsible for ensuring the provider is still a participating BCBS PPO network provider each time you schedule an appointment. Reimbursement for covered services will be subject to the applicable copayment or deductible, and coinsurance amounts. You will be responsible for services that are not covered or not approved by BCBSTX.

Benefits will be payable at the out-of-network level should you choose to receive covered health care services from a provider who is not in a BCBS PPO network.

IDENTIFICATION CARDS

Enclosed are new ID cards with the PPO logo in a suitcase. This new logo is a visual symbol that providers will use to identify you as a BlueCard PPO subscriber. The ID cards also reflect a new assigned three-character alpha prefix code immediately preceding your subscriber number.

When receiving care outside your local plan service area, simply present your PPO ID card to the network provider to receive the in-network benefits provided through your health plan.

It is important that you always present your new PPO ID card to network providers to ensure your records are updated and to facilitate proper claims filing. Upon receipt, destroy your existing ID cards and immediately replace them with the new ones.

BLUECARD ACCESS

You may obtain information regarding BCBS PPO network providers and hospitals by calling the Customer Service telephone number located on the back of your ID card or the BlueCard Access Telephone number at 1-800-810-BLUE (2583) when medical services are warranted outside of your local plan service area.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE, ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies, which are members of the Association, are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the Texas Insurance Code, Article 21.28-D).

BECAUSE OF STATUTORY LIMITATION ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company, which is a member of the Association, is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to the policyholders who are:

- residents of Texas at the time that their insurance company is impaired
- residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company based in Texas;
  2. The company has never held a license in the policyholder's state of residence;
  3. The policyholder's state of residence has a similar guaranty association; and
  4. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- up to a total of $200,000 for one or more policies for each individual covered.

Life Insurance:

- net cash surrender value up to a total of $100,000 under one or more policies on any one life; or
- death benefits up to a total of $300,000 under one or more policies on any one life.

Individual Annuities:

- net cash surrender amount up to a total of $100,000 under one or more policies owned by one contractholder.

Group Annuities:

- net cash surrender amount up to $100,000 in allocated benefits under one or more policies owned by one contractholder, or
- net cash surrender amount up to $5,000,000 in unallocated benefit under one contractholder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

When you are selecting an insurance company, you should not rely on coverage by the Association.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
301 Congress, Suite 500
Austin, Texas 78701
800-982-6362

Texas Department of Insurance
P. O. Box 149104
Austin, Texas 78714-9104
800-252-3439

Your Privacy with Blue Cross and Blue Shield of Texas

This notice requires no actions on your part. It is designed to help you understand how we protect your personal information.

Your private records and those of your covered family members are safe with Blue Cross and Blue Shield of Texas. The company has a longstanding policy that maintains the confidentiality of the personal data necessary to administer insurance and to provide service. As you know, many companies sell the names of customers to others. We at Blue Cross and Blue Shield of Texas and our affiliates do not sell or rent your name or your records to any other organization or business concern.

Confidentiality and Security

Blue Cross and Blue Shield has set out strict policies and procedures to protect the confidentiality of personal information. We also maintain physical, electronic, and procedural safeguards to protect personal data from unauthorized access and unanticipated threats or hazards.

Information That May Be Collected

Information is provided by you on application, claim and other forms. We also have personal information from your transactions with us, such as information about your policies, premiums and claims. This information may come by telephone, in writing or through a computer. In addition we may receive information from your health care providers through the course of managing insurance transactions or from our affiliates or others, e.g., insurance administrators, consultants, etc., which may be doing work for Blue Cross and Blue Shield.

Independent Insurance Agents

The independent insurance agents authorized to sell Blue Cross and Blue Shield products and the products of our affiliates are not employees and are not subject to our Privacy Policy. Because they have a unique business relationship with you, they may have additional personal information about you and/or your family members that we do not have. Your agent may have access to information needed to provide service to you. Since this agent is subject to the same privacy laws that govern us, this agent may have privacy obligations to you which are independent of ours.

BlueCross BlueShield
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

Notice to Blue Cross and Blue Shield of Texas Subscriber/Policyholder

BlueCard Program Savings

Your Blue Cross and Blue Shield membership card – The BlueCard – gives you access to health care throughout the United States. Through the BlueCard Program, your membership card indicates to any participating hospital or physician which Blue Cross and/or Blue Shield Plan is yours. By using this BlueCard, you can help keep your costs down when you need health care away from home.

When you obtain health care services outside Texas and through the BlueCard Program, the coinsurance or co-share amount you pay is calculated based on either the billed charge the provider of health care charges for your covered services, or the "negotiated price" that the local Blue Cross and/or Blue Shield Plan passes on to Blue Cross and Blue Shield of Texas ("BCBSTX"), whichever is *less*.

Below are some frequently–asked questions that will help illustrate the claims calculation. For further information, you may write BCBSTX at P.O. Box 655488, Dallas, Texas, 75265-5488.

What's a "negotiated price"?

In many cases, the local Blue Cross and/or Blue Shield Plan obtains a discount from the provider's billed charges that is passed on to BCBSTX. A number of Plans can determine only an estimated price at the time your claim is paid. In addition, some Plans' provider contracts do not give a comparable discount for all claims. These Plans elect to smooth out the effect of their contracts by applying an average discount to BlueCard Program claims. Plans using these methods may prospectively adjust their estimated or average prices to correct for over- or underestimation of past prices.

Give me an example of how you calculate my liability.

Let's assume that you are on vacation in another state, you get sick, and you see a participating doctor for a particular medical service. Let's also assume your plan or policy requires you to pay 20% of the allowable amount (after a deductible). The particular doctor you receive services from has negotiated with the local Blue Cross and Blue Shield Plan a price of $160, even though his standard charge for this service is $200. The doctor bills the local Plan the standard charge of $200, but we base your share of the claim on the negotiated price of $160. In this case, the amount you pay (the "coinsurance" or "co-share amount") is $32 (20% of $160) rather than $40 (20% of $200).

Does BlueCard always work this way?

A few Blue Cross and/or Blue Shield Plans are governed by state laws that do not allow your coinsurance or co-share amount to be calculated using the "lesser of" the billed charge or the negotiated price. In those instances, BCBSTX will *recalculate* your claim using the "lesser of" formula and issue you a supplemental check if there is a difference of more than $5. So, in the example above, if you were charged $40 (20% of the billed charge of $200) rather than $32 (20% of the negotiated price), BCBSTX would send you a supplemental check for $8 (the difference between $40 you had to pay and $32 you should have paid).

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

Policyholder/Subscriber Liability Amendment

The following section is added to and made a part of the individual policy currently in force between Blue Cross and Blue Shield of Texas ("BCBSTX") and the Policyholder/Subscriber, or the booklet describing the benefits for participants of employer or association-sponsored medical plans:

Calculation of Participant Coinsurance Liability

If you incur expenses under the Policy or Plan in a location outside of Texas and through the BlueCard Program, your liability for coinsurance or co-share will be calculated on the lesser of:

- the billed charge of the provider of health care, or
- the negotiated rate BCBSTX pays the local Blue Cross and/or Blue Shield Plan.

The negotiated rate may represent:

1. the actual price paid on the claim,

2. an estimated price that reflects adjusted aggregate payments expected to result from settlements or other non-claims transactions with one or more of the local Plan's health care providers, or

3. a discount from billed charges representing the local Plan's expected average savings for all of its providers or for a specified group of providers.

Plans using either the estimated price or average savings factor methods may prospectively adjust the estimated or average price to correct for overestimation or underestimation of past prices.

Some states' statutes may require local Blue Cross and/or Blue Shield Plans to use a basis of computing your liability for coinsurance or co-share that does not reflect the entire discount. In those instances, BCBSTX will recalculate the amount of the claim using the "lesser of" methodology and adjust your coinsurance or co-share liability accordingly.

Understanding and acceptance of this amendment is deemed by Policyholder/Subscriber by payment of premium or other consideration in the month next following receipt of this amendment.

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

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.

An Amendment

To be inserted in your Blue Cross and Blue Shield of Texas "Select 2000" Contract describing your individual insurance plan

Your Contract is amended as follows:

Wherever the term **"Certified Social Worker-Advanced Clinical Practitioner"** appears in your Contract, the term **"Licensed Master Social Worker-Advanced Clinical Practitioner"** is substituted.

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

President

Attest:

Secretary

An Amendment

To be inserted in Blue Cross and Blue Shield of Texas, Inc.* Contract describing your individual Contract insurance plan.

1. Wherever the term "Reasonable Charge" appears in your Contract it is hereby replaced with "Allowable Amount."

2. Article I of the Contract is amended by deleting the definition of **"Reasonable Charge"** and replacing it with the following:

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

   1. For Providers contracting with BCBSTX, Allowable Amount is based on the terms of the contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), relative value, resource based relative value scale (RBRVS), fee schedule, package pricing, global pricing, or other payment methodologies.
   2. For Hospitals and Facility Other Providers in Texas not contracting with BCBSTX, no payment will be made by BCBSTX.
   3. For procedures, services or supplies provided in Texas by Physicians and Professional Other Providers not contracting with BCBSTX, Allowable Amount shall be the lesser of the billed charge or the amount BCBSTX 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 in the same locale, as determined by BCBSTX from data BCBSTX has compiled.

      If BCBSTX does not have sufficient data to calculate the Allowable Amount for a particular procedure, service or supply, BCBSTX will determine an Allowable Amount based on the complexity of the procedure, service or supply and any unusual circumstances or medical complications specifically brought its attention, which require additional experience, skill and/or time.
   4. For procedures, services or supplies performed outside Texas by Physicians or Professional Other Providers not contracting with BCBSTX or any other Blue Cross and Blue Shield Plan, BCBSTX will establish an Allowable Amount using, at its option, Dallas County or Texas statewide profiles of charges applicable to procedures, services or supplies of Physicians or Professional Other Providers with similar skills and experience.
   5. For multiple surgeries, if there is not a unique Allowable Amount for multiple surgeries performed through the same incision or in the same operative area, the Allowable Amount for all procedures combined 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.
   6. 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 markup. AWP means the average wholesale price of a drug on the date the drug is administered by the Home Infusion Therapy Provider. The AWP is taken from nationally recognized sources in current use.

7. For services, supplies or procedures provided to Medicare recipients, the Allowable Amount will not exceed Medicare's limiting charge.

Blue Cross and Blue Shield of Texas, Inc. (BCBSTX)

President

An Amendment

Effective January 1, 1998

To be inserted in your Blue Cross and Blue Shield of Texas, Inc.* Contract describing your individual insurance plan.

1. The face page of the Contract is amended by deleting the wording of the first sentence in its entirety and substituting the following:

   Notice: 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.

2. Article I of the Contract is amended as follows:

   a. The definition of **"Medical-Surgical Expense"** is amended by deleting the wording of item 6 in its entirety and substituting the following:

      6. Drugs and medicines, including injectable drugs, purchased for use outside of a Hospital which require a written prescription for purchase in those limited quantities required for the immediate therapeutic needs of the Participant while covered under the Contract (not including Home Infusion Therapy items) up to a maximum benefit amount of $1,000 per Participant each Calendar Year. Benefits for charges deemed to be in excess of the Participant's own immediate therapeutic needs may be denied, or if already paid, will be recoverable upon later review.

   b. The definition of **"Medical-Surgical Expense"** is amended by adding the following new item:

      Diabetic Equipment and Supplies which shall include prescription orders for insulin, insulin analogs, prescriptive and nonprescriptive oral agents for controlling blood sugar levels.

   c. The definition of **"Other Provider"** is amended by adding the following new Professional Other Providers:

      Advanced Practice Nurse
      Licensed Occupational Therapists
      Licensed Physical Therapists
      Physician's Assistant

   d. The definition of **"Second Surgical Opinion Services"** is deleted in its entirety.

   e. Adding the following new definitions:

      Creditable Coverage means coverage under any one of the following:

      1. 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
      2. Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; or
      3. Part A or Part B of Title XVIII of the Social Security Act (Medicare); or

*An independent licensee of the Blue Cross and Blue Shield Association

4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; or
5. Chapter 55 of Title 10, United States Code; or
6. A medical care program of the Indian Health Service or of a tribal organization; or
7. A state health benefits risk pool; or
8. A plan offered under Chapter 89 of Title 5, United States Code; or
9. A public health plan as defined by federal regulations; or
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C., Section 2504(e)).

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;

Diabetic Equipment and Supplies means those items of *Medical-Surgical Expense* associated with the treatment of diabetes. Such items, when obtained for a ***qualified participant***, may include the following:

1. Diabetic Equipment

    a. Blood glucose monitors,
    b. Insulin pumps and necessary accessories,
    c. Insulin infusion devices, and
    d. Podiatric appliances for the prevention of complications associated with diabetes.

2. Diabetic Supplies

    a. Test strips for blood glucose monitors,
    b. Visual reading and urine test strips,
    c. Lancets and lancet devices,
    d. Insulin and insulin analogs,
    e. Injection aids, and

f. Syringes,
g. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and
h. Glucagon emergency kits.

Injectable insulin shall be limited to no more than four 10cc vials on any occasion when the insulin is dispensed. The quantity of disposable syringes and needles covered for self-administered injections shall be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles on any occasion dispensed.

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.

Health Status Related Factor means:

1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of family violence; and
8. Disability.

3. Article IV, Section A, of the Contract is amended by deleting the wording of Subsection 1 in its entirety and substituting the following:

1. **Inpatient Precertification**

Precertification is required for each Hospital Admission. The length-of-stay of your Hospital Admission must be precertified two working days prior to the actual admission, (except in the case of an emergency admission) in order to ensure that the length-of-stay of the admission is Medically Necessary. The length-of-stay of an emergency Hospital Admission must be precertified within two working days following the admission, or as soon thereafter as reasonably possible.

Precertification of a Hospital Admission does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the approved length-of-stay will not be denied on the basis of Medical Necessity.

At the time inpatient precertification is requested, the Carrier will assign a length-of-stay for the Hospital Admission if it determines that the Hospital Admission is Medically Necessary. The Carrier will provide minimum length-of-stay of:

a. If the Maternity Care Option was selected,

(1) 48 hours following an uncomplicated vaginal delivery; and
(2) 96 hours following an uncomplicated delivery by caesarean section.

b. Treatment of Breast Cancer,

(1) 48 hours following a mastectomy, and
(2) 24 hours following a lymph node dissection.

Upon request, the length-of-stay may be extended if the Carrier determines that an extension is 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 Amount. Additionally, the Carrier will review the Medical Necessity of your claim.

4. Article IV, Section D, is amended by deleting the wording of Subsection 2 in its entirety.

5. Article IV of the Contract is amended by deleting the wording of the subsection entitled **"Benefits for Well-Child Care"** in its entirety and substituting the following:

Benefits for Well-Child Care

If a Dependent child through age seven incurs *Medical-Surgical Expense* for *Well-Child Care*, benefits shall be provided on the same basis as for any other sickness.

Well-Child Care means a program of periodic physical examination and developmental assessment for a child through age seven.

6. Article IV of the Contract is amended by adding the following new benefit provisions:

Childhood Immunizations

Benefits for *Medical-Surgical Expense* incurred by a Dependent child through age seven for childhood immunizations will be determined at 100% of the Allowable Amount. The Deductible and Coinsurance Amount will not be applicable. Benefits are available for:

(1) Diphtheria,
(2) Hemophilus influenza type b,
(3) Hepatitis B,
(4) Measles,
(5) Mumps,
(6) Pertussis,
(7) Polio,
(8) Rubella,
(9) Tetanus,
(10) Varicella, and
(11) Any other immunization that is required by law for the child.

Allergy injections are not considered immunizations under this benefit provision.

Certain Tests for the 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 on the same basis as for any other sickness. Benefits will only be provided for:

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

(2) A prostate-specific antigen test used for the detection of prostate cancer for each male Participant under this Contract who is at least:

(a) 50 years of age and asymptomatic; or
(b) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

7. Article V of the Contract is amended by deleting the wording of Section 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:

a. Mammography screening,
b. Well-Child Care,
c. Childhood Immunizations, and
d. Certain tests for the detection of prostate cancer.

8. Article V of this Contract is amended by deleting the wording of Section S in its entirety and substituting the following:

S. Any services or supplies provided for Cosmetic, Reconstructive or Plastic Surgery, except for the following:

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

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

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

(4) 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.

(5) Surgical reconstruction of a breast on which mastectomy surgery has:

(a) Been performed; and
(b) Not been performed.

Surgical reconstruction of the breast means the services or supplies necessary to restore or achieve breast symmetry.

9. Article V of this Contract is amended by deleting the wording of Section AI in its entirety and substituting the following:

AI. 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 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, governmental plan or church plan.

If a Participant's most recent prior Creditable Coverage was under a group health plan, a governmental plan, or a church plan, but he does not have aggregate Creditable Coverage totaling 18 months, BCBSTX 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 (a) the first day coverage is effective under this Contract, if there is not a waiting period; or (b) the day the applicant files a substantially complete application for coverage, if there is a waiting period.

10. Article VI of this Contract is deleted in its entirety and replaced with the following:

Article VI — Termination of Coverage

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

1. On the last day of the last period for which the premium for this Contract has been paid to the Carrier, subject to the grace period provided in Article VII, Section C; or
2. On the last day of any Contract Month upon written request for termination of this Contract made by the Subscriber and received by the Carrier prior thereto; or
3. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
4. On the date of death of the Subscriber; or
5. On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor; or
6. On date following 90 days advance notice by the Carrier to the Subscriber, but only if it is then terminating in like fashion all other Form No. SEL-4 Select 2000SM Plan Contract; provided that under this Subsection 6:

   a. Coverage for any continuous illness (except for pregnancy) 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 to:

      (1) The duration of the policy benefit period,

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

      (3) To a period of not less than 90 days,

      "Total Disability," for purposes of this Subsection 6, 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.

   b. Coverage for pregnancy which commenced while this Contract was in force and for which benefits would have been available, shall at termination, continue to the end of such pregnancy.

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

1. At the end of the Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section K, of this Contract, provided that if such date falls within a period for which premium has been accepted by the Carrier, coverage shall not terminate until the last day of such period; or
2. On the date of death of the Dependent; or

3. 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 the Carrier prior thereto; or

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

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

D. Notwithstanding the provisions of Section B, 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, the Carrier 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 D shall terminate if no application is received by the Carrier within the 30-day period.

Blue Cross and Blue Shield of Texas, Inc. (BCBSTX)

President

An Amendment

Effective January 1, 1998

To be inserted in your Blue Cross and Blue Shield of Texas, Inc.* Contract describing your individual insurance plan.

1. The face page of this Contract is amended by deleting the wording of the first sentence in its entirety and substituting the following:

   Notice: 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.

2. Article I of the Contract is amended as follows:

   a. The definition of **"Medical-Surgical Expense"** is amended by deleting the wording of item 6 in its entirety and substituting the following:

      6. Drugs and medicines, including injectable drugs, purchased for use outside of a Hospital which require a written prescription for purchase in those limited quantities required for the immediate therapeutic needs of the Participant while covered under the Contract (not including Home Infusion Therapy items) up to a maximum benefit amount of $1,000 per Participant each Calendar Year. Benefits for charges deemed to be in excess of the Participant's own immediate therapeutic needs may be denied, or if already paid, will be recoverable upon later review.

   b. The definition of **"Medical-Surgical Expense"** is amended by adding the following new item:

      Diabetic Equipment and Supplies which shall include prescription orders for insulin, insulin analogs, prescriptive and nonprescriptive oral agents for controlling blood sugar levels.

   c. The definition of **"Other Provider"** is amended by adding the following new Professional Other Providers:

      Advanced Practice Nurse
      Licensed Occupational Therapists
      Licensed Physical Therapists
      Physician's Assistant

   d. The definition of **"Second Surgical Opinion Services"** is deleted in its entirety.

   e. Adding the following new definitions:

      Creditable Coverage means coverage under any one of the following:

      1. 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
      2. Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; or
      3. Part A or Part B of Title XVIII of the Social Security Act (Medicare); or

*An independent licensee of the Blue Cross and Blue Shield Association

4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; or
5. Chapter 55 of Title 10, United States Code; or
6. A medical care program of the Indian Health Service or of a tribal organization; or
7. A state health benefits risk pool; or
8. A plan offered under Chapter 89 of Title 5, United States Code; or
9. A public health plan as defined by federal regulations; or
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C., Section 2504(e)).

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;

Diabetic Equipment and Supplies means those items of *Medical-Surgical Expense* associated with the treatment of diabetes. Such items, when obtained for a ***qualified participant***, may include the following:

a. Diabetic Equipment

(1) Blood glucose monitors,
(2) Insulin pumps and necessary accessories,
(3) Insulin infusion devices, and
(4) Podiatric appliances 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,
(3) Lancets and lancet devices,
(4) Insulin and insulin analogs,
(5) Injection aids, and

(6) Syringes,
(7) Prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and
(8) Glucagon emergency kits.

Injectable insulin shall be limited to no more than four 10cc vials on any occasion when the insulin is dispensed. The quantity of disposable syringes and needles covered for self-administered injections shall be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles on any occasion dispensed.

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.

Health Status Related Factor means:

1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of family violence; and
8. Disability.

3. Article IV, Section A, of the Contract is amended by deleting the wording of Subsection 1 in its entirety and substituting the following:

1. **Inpatient Precertification**

Precertification is required for each Hospital Admission. The length-of-stay of your Hospital Admission must be precertified two working days prior to the actual admission, (except in the case of an emergency admission) in order to ensure that the length-of-stay of the admission is Medically Necessary. The length-of-stay of an emergency Hospital Admission must be precertified within two working days following the admission, or as soon thereafter as reasonably possible.

Precertification of a Hospital Admission does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the approved length-of-stay will not be denied on the basis of Medical Necessity.

At the time inpatient precertification is requested, the Carrier will assign a length-of-stay for the Hospital Admission if it determines that the Hospital Admission is Medically Necessary. The Carrier will provide minimum length-of-stay for treatment of Breast Cancer (a) 48 hours following a mastectomy, and (b) 24 hours following a lymph node dissection.

Upon request, the length-of-stay may be extended if the Carrier determines that an extension is 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

7. Article V of the Contract is amended by deleting the wording of Section 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:

      a. Mammography screening,
      b. Well-Child Care,
      c. Childhood Immunizations, and
      d. Certain tests for the detection of prostate cancer.

8. Article V of this Contract is amended by deleting the wording of Section S in its entirety and substituting the following:

   S. Any services or supplies provided for Cosmetic, Reconstructive or Plastic Surgery, except for the following:

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

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

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

      (4) 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.

      (5) Surgical reconstruction of a breast on which mastectomy surgery has:

         (a) Been performed; and
         (b) Not been performed.

         Surgical reconstruction of the breast means the services or supplies necessary to restore or achieve breast symmetry.

9. Article V of this Contract is amended by deleting the wording of Section AI in its entirety and substituting the following:

   AI. 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 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.

      <u>If a Participant's most recent prior Creditable Coverage was under a group health plan, a governmental plan, or a church plan, but he does not have aggregate Creditable Coverage totaling 18 months, BCBSTX 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 (a) the first day coverage is effective under this Contract, if there is not a waiting period; or (b) the day the applicant files a substantially complete application for coverage, if there is a waiting period.</u>

10. Article VI of this Contract is deleted in its entirety and replaced with the following:

Article VI — Termination of Coverage

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

1. On the last day of the last period for which the premium for this Contract has been paid to the Carrier, subject to the grace period provided in Article VII, Section C; or
2. On the last day of any Contract Month upon written request for termination of this Contract made by the Subscriber and received by the Carrier prior thereto; or
3. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
4. On the date of death of the Subscriber; or
5. On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor; or
6. On the date following 90 days advance notice by the Carrier to the Subscriber, but only if it is then terminating in like fashion all other Form No. SEL-4 Select 2000℠ Plan Contract; provided that under this Subsection 6, coverage for any continuous illness (except for pregnancy) 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 to:

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

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

   (3) To a time period of not less than 90 days.

   "Total Disability," for purposes of this Subsection 6, 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.

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

1. At the end of the Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section K, of this Contract, provided that if such date falls within a period for which premium has been accepted by the Carrier, coverage shall not terminate until the last day of such period; or
2. On the date of death of the Dependent; or
3. 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 the Carrier prior thereto; or
4. On the last day of any Contract Month in which a Dependent no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor.

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

D. Notwithstanding the provisions of Section B, 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, the Carrier 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 D shall terminate if no application is received by the Carrier within the 30-day period.

Blue Cross and Blue Shield of Texas, Inc. (BCBSTX)

President

An Amendment

Effective January 1, 2003

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:

Article I of this Contract is amended by adding the following new Professional Other Provider:

- Surgical Assistant

Patricia Hemingway Hall

President

BLUE CROSS AND BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORPORATION
Richardson, Texas

Name Change Endorsement

This endorsement is made a part of the policy or certificate to which it is attached.

Blue Cross and Blue Shield of Texas, Inc.

has changed its name as a result of a merger with
Health Care Service Corporation, a Mutual Legal Reserve Company
d/b/a Blue Cross and Blue Shield of Illinois, which does business in Texas as
Blue Cross and Blue Shield of Texas,
a Division of Health Care Service Corporation to:

Blue Cross and Blue Shield of Texas,
A Division of Health Care Service Corporation

The Company's Home Office Address is:
300 East Randolph
Chicago, Illinois 60601

The Company's Administrative Office Address is:
901 S. Central Expressway
Richardson, Texas 75080

President

Secretary

An Amendment

Effective January 1, 2005 and thereafter

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:

Article I of this Contract is amended by deleting the definition of "Creditable Coverage" in its entirety and substituting the following:

Creditable Coverage means coverage under any one of the following:

a. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;

b. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
   (1) group health insurance coverage;
   (2) individual health insurance coverage; and
   (3) short-term, limited-duration insurance;

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

d. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);

e. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services, and for their dependents);

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

g. A State health benefits risk pool;

h. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);

i. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides heath coverage to individuals who are enrolled in the plan;

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

k. Title XXI of the Social Security Act (State Children's Health Insurance Program.)

Creditable Coverage does not include:

a. Coverage only for accident (including accidental death and dismemberment);

b. Disability income coverage;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Coverage issued as a supplement to liability insurance;

e. Workers' compensation or similar coverage;

f. Automobile medical payment insurance;

g. Credit-only insurance (for example, mortgage insurance);

h. Coverage for onsite medical clinics;

i. Limited scope dental benefits, visions benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance;

j. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;

k. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;

l. Medicare supplemental health insurance (as defined under section 1882(g)(1)of the Social Security Act; also known as Medigap or MedSupp insurance);

m. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and

n. Similar supplemental coverage provided to coverage under a group health plan.

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.

Blue Cross and Blue Shield of Texas

By: Patricia Hemingway Hall
President

Date: _____

An Amendment

Effective January 1, 1998

1. The **Definitions** section of Your Contract is amended as follows:

   a. The definition of **Medical-Surgical Expense** is amended by adding the following new item:

      Diabetic Equipment and Supplies which shall include prescription orders for insulin, insulin analogs, prescriptive and nonprescriptive oral agents for controlling blood sugar levels.

   b. The definition of **Other Provider** is amended by adding the following new Professional Other Providers:

      Advanced Practice Nurse
      Licensed Occupational Therapists
      Licensed Physical Therapists
      Physician's Assistant

   c. Adding the following new definitions:

      Creditable Coverage means coverage under any one of the following:

      1. 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
      2. Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; or
      3. Part A or Part B of Title XVIII of the Social Security Act (Medicare); or
      4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; or
      5. Chapter 55 of Title 10, United States Code; or
      6. A medical care program of the Indian Health Service or of a tribal organization; or
      7. A state health benefits risk pool; or
      8. A plan offered under Chapter 89 of Title 5, United States Code; or
      9. A public health plan as defined by federal regulations; or
      10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C., Section 2504(e)).

      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;

Diabetic Equipment and Supplies means those items of *Medical-Surgical Expense* associated with the treatment of diabetes. Such items, when obtained for a ***qualified participant***, shall include the following:

1. Diabetic Equipment
   a. Blood glucose monitors, including monitors for the blind
   b. Insulin pumps and necessary accessories,
   c. Insulin infusion devices, and
   d. Podiatric appliances for the prevention of complications associated with diabetes.

2. Diabetic Supplies
   a. Test strips for blood glucose monitors,
   b. Visual reading and urine test strips,
   c. Lancets and lancet devices,
   d. Insulin and insulin analogs,
   e. Injection aids,
   f. Syringes,
   g. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and
   h. Glucagon emergency kits.

Injectable insulin shall be limited to no more than four 10cc vials on any occasion when the insulin is dispensed. The quantity of disposable syringes and needles covered for self-administered injections shall be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles on any occasion dispensed.

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.

Health Status Related Factor means:

1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;

5. Medical history;
6. Genetic information;
7. Evidence of insurability, including conditions arising out of acts of family violence; and
8. Disability.

2. The **Benefits Provided** section of Your Contract is amended by deleting the wording of **Hospital Admissions** in its entirety and substituting the following:

Hospital Admissions

At the time inpatient precertification is requested, the Carrier will assign a length-of-stay for the Hospital Admission if it determines that the Hospital Admission is Medically Necessary. The Carrier will provide minimum length-of-stay of:

a. If the Maternity Care Option was selected,

(1) 48 hours following an uncomplicated vaginal delivery; and
(2) 96 hours following an uncomplicated delivery by caesarean section.

b. Treatment of Breast Cancer,

(1) 48 hours following a mastectomy, and
(2) 24 hours following a lymph node dissection.

Upon request, the length-of-stay may be extended if the Carrier determines that an extension is 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 Amount. Additionally, the Carrier will review the Medical Necessity of your claim.

3. The **Benefits Provided** section of Your Contract is amended by deleting the wording of the subsection entitled **"Benefits for Well-Child Care"** in its entirety and substituting the following:

Benefits for Well-Child Care

If a Dependent child through age seven incurs *Medical-Surgical Expense* for *Well-Child Care*, benefits shall be provided on the same basis as for any other sickness.

Well-Child Care means a program of periodic physical examination and developmental assessment for a child through age seven.

4. The **Benefits Provided** section of Your Contract is amended by adding the following new benefit provisions:

Benefits for Childhood Immunizations

Benefits for *Medical-Surgical Expense* incurred by a Dependent child through age seven for childhood immunizations will be determined at 100% of the Allowable Amount. The Deductible and Coinsurance Amount will not be applicable. Benefits are available for:

(1) Diphtheria,
(2) Hemophilus influenza type b,
(3) Hepatitis B,
(4) Measles,
(5) Mumps,
(6) Pertussis,
(7) Polio,
(8) Rubella,
(9) Tetanus,
(10) Varicella, and
(11) Any other immunization that is required by law for the child.

Allergy injections are not considered immunizations under this benefit provision.

Benefits for Certain Tests for the 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 on the same basis as for any other sickness. Benefits will only be provided for:

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

(2) A prostate-specific antigen test used for the detection of prostate cancer for each male Participant under this Contract who is at least:

    (a) 50 years of age and asymptomatic; or
    (b) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

5. The **Limitations and Exclusions** section of Your Contract is amended by deleting the exclusion regarding "routine physical examinations" in entirety and substituting the following:

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:

1. Mammography Screening,
2. Well-Child Care,
3. Childhood Immunizations, and
4. Certain Tests for the Detection of Prostate Cancer.

6. The **Limitations and Exclusions** section of Your Contract is amended by deleting the exclusion regarding "Cosmetic, Reconstructive or Plastic Surgery" in entirety and substituting the following:

   Any services or supplies provided for Cosmetic, Reconstructive or Plastic Surgery, except for the following:

   1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant while covered under this Contract; or
   2. Treatment provided for reconstructive surgery following cancer surgery while the Participant is covered under this Contract; or
   3. Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
   4. 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.
   5. Surgical reconstruction of a breast on which mastectomy surgery has:

      (a) Been performed; and
      (b) Not been performed.

   Surgical reconstruction of the breast means the services or supplies necessary to restore or achieve breast symmetry.

7. The **Limitations and Exclusions** section of Your Contract is amended by deleting the exclusion regarding "Preexisting Conditions" in entirety and substituting the following:

   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 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, governmental plan or church plan.

   If a Participant's most recent prior Creditable Coverage was under a group health plan, a governmental plan, or a church plan, but he does not have aggregate Creditable Coverage totaling 18 months, BCBSTX 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 (a) the first day coverage is effective under this Contract, if there is not a waiting period; or (b) the day the applicant files a substantially complete application for coverage, if there is a waiting period.

8. The **Termination of Coverage** section of Your Contract is deleted in its entirety and replaced with the following:

Article VI — Termination of Coverage

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

      1. On the last day of the last period for which the premium for this Contract has been paid to the Carrier, subject to the grace period provided in Article VII, Section C; or
      2. On the last day of any Contract Month upon written request for termination of Your Contract made by the Subscriber and received by the Carrier prior thereto; or

3. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
4. On the date of death of the Subscriber; or
5. 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
6. On date following 90 days advance notice by the Carrier to the Subscriber, but only if it is terminating all other contracts of this class; provided that the Carrier offers any hospital, medical or surgical insurance coverage on a guaranteed basis to all applicants at the time of discontinuance of Your Contract.
7. In the event this Contract is terminated in accordance with the provisions of Subsection 6, above, a Participant does not elect to purchase another individual hospital, medical or surgical insurance policy:
   a. Coverage for any continuous illness (except for pregnancy) 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 to:
      (1) The duration of the policy benefit period,
      (2) Payment of maximum benefits under this Contract, or
      (3) To a period of not less than 90 days.

      "Total Disability," for purposes of this Subsection 7, 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.

   b. Coverage for pregnancy which commenced while this Contract was in force and for which benefits would have been available, shall at termination, continue to the end of such pregnancy.

8. The Carrier may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if the Carrier:
   a. Notifies 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 insurance plan terminates;
   b. Notifies each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and
   c. Act uniformly without regard to any Health Status Related Factor of covered individuals who may become eligible for coverage.

B. In addition to the provisions of Section A, above, the coverage of any Dependent under this Contract shall terminate on the earliest of the following dates:
   1. At the end of Your Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section K, of Your Contract, provided that if such date falls within a period for which premium has been accepted by the Carrier, coverage shall not terminate until the last day of such period; or
   2. On the date of death of the Dependent; or
   3. 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 the Carrier prior thereto; or

4. 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.

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

D. Notwithstanding the provisions of Section B, 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, the Carrier 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 D shall terminate if no application is received by the Carrier within the 30-day period.

Effective January 1, 2000

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1. The **Definitions** section of Your Contract is amended in the definition of **Medical-Surgical Expense** by adding the following subsection:

   In regards to drugs and medicines above, Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given are covered as required by law or regulation.

2. The **Definitions** section of Your Contract is amended in the definition of **Other Provider** by:

   a. Adding the following to **Professional Other Provider**:

      - Licensed Acupuncturist

   b. Changing the name of **Licensed Hearing Aid Fitter and Dispenser** to **Licensed Hearing Instrument Fitter and Dispenser.**

3. The **Benefits Provided** section of Your Contract is amended as follows:

   a. The section entitled **Benefits for Cosmetic, Reconstructive, or Plastic Surgery** is amended by deleting the subsection (e) in its entirety and substituting the following:

      (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.

b. The section entitled **Benefits for Cosmetic, Reconstructive, or Plastic Surgery** is amended by adding the following new subsection (f):

(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.

c. The subsection entitled **Benefits for Childhood Immunizations** is changed to **Required Benefits for Childhood Immunizations.**

d. By adding the following new benefit provisions:

Required Benefits for Screening Test for Hearing Impairment

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

- 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 test from birth through the date the child is 24 months old.

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

4. The **Benefits Provided** section of Your Contract is amended by adding the following new benefit provision:

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetic 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:

a. Diabetic Equipment

(1) Blood glucose monitors (including noninvasive glucose monitors and monitors designed to be used by 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 Benefit Period, 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 needleless systems,

(6) Biohazard disposable containers,

(7) Insulin syringes,

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

(9) Glucagon emergency kits.

However, insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, for controlling blood sugar levels, including prescription medications which are required by law to be labeled "Caution: Federal Law prohibits dispensing without a prescription", 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. Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetic 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 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 family or caretaker) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

A ***qualified participant*** means an individual eligible for coverage under this 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.

5. The **Limitations and Exclusions** section of Your Contract is amended by deleting the exclusion regarding "routine physical examinations" in entirety and substituting the following:

   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 Your Contract:

   1. Mammography screening,
   2. Well Child Care,
   3. Childhood Immunizations,
   4. Certain Tests for the Detection of Prostate Cancer; or
   5. Screening Tests for Hearing Impairment.

6. The **Limitations and Exclusions** section of Your Contract is amended by deleting the exclusion regarding "Licensed Hearing" in entirety and substituting the following:

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

7. The **Limitations and Exclusions** section of Your Contract is amended by deleting the wording of the exclusion regarding "Speech and Hearing Services" in its entirety and substituting the following:

   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 Your Contract:

   1. *Extended Care Expense*;
   2. Well Child Care; and
   3. Newborn Screening Tests for Hearing Impairment.

Effective January 1, 2002

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1. The **Definitions** section of Your Contract is amended by deleting the definition of **Dependent** in its entirety and substituting the following:

   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. The **Definitions** section of Your Contract is amended by adding the following new subsections to the definition of **Medical-Surgical Expense**.

Outpatient Contraceptive Services and prescription contraceptive devices.
Telehealth Service and Telemedicine Medical Service.

3. The **Definitions** section of Your Contract is amended by deleting the definition of **Other Provider** in its entirety and substituting the following:

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 Infusion Therapy Provider
3. Imaging Center
4. Independent Laboratory
5. Prosthetic/Orthotics Provider
6. Renal Dialysis Center
7. 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 Chemical Dependency Counselor
10. Licensed Clinical Social Worker
11. Licensed Dietitian
12. Licensed Hearing Instrument Fitter and Dispenser
13. Licensed Physical Therapist
14. Licensed Professional Counselor
15. Licensed Occupational Therapist
16. Licensed Speech-Language Pathologist
17. Marriage and Family Therapist
18. Nurse First Assistant
19. Physician Assistant
20. Psychological Associate who practices solely under a Licensed Psychologist
21. 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.

4. The **Definitions** section of Your Contract is amended by adding the following new definitions:

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury 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.

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. The **Benefits Provided** section of Your Contract is amended by adding the following new benefit provisions:

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.

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 on the same basis as for any other sickness for a:

- Fecal occult blood test performed annually and flexible sigmoidoscopy performed every five years; or
- Colonoscopy performed every ten years.

6. The **Limitations and Exclusions** section of Your Contract is amended by deleting the exclusion regarding "routine physical examinations" in entirety and substituting the following:

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 Your Contract:

1. Mammography Screening,
2. Well Child Care,
3. Childhood Immunizations,
4. Certain Tests for the Detection of Prostate Cancer,

5. Newborn Screening Tests for Hearing Impairment, or
6. Certain Tests for the Detection of Colorectal Cancer.

7. The **Termination of Coverage** section of Your Contract is amended by deleting the wording of Section 2a in its entirety and substituting the following:

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

      - If such date falls within a period for which the Carrier has accepted premium, coverage shall not terminate until the last day of such period; or

      - 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 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 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 age 25, 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 25.

8. The **Termination of Coverage** section of Your 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.

9. The **Termination of Coverage** section of Your Contract is amended by deleting item b of the wording in the subsection regarding "Disclosure Authorization" 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 not more frequently than annually after the two-year period following the child's attainment of age 25.

1. The **Definitions** section of Your Contract is amended in the term "Other Provider" by deleting the term "Licensed Master Advanced-Clinical Social Worker" and substituting "Licensed Clinical Social Worker."

2. The **Benefits Provided** section of Your 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 Your Contract will apply, including but not limited tom defined terms, limitations and exclusions, preexisting conditions, and benefit maximums.

3. The **Limitations and Exclusions** section of Your Contract is amended by deleting the wording of the exclusion regarding "Dietary and Nutritional Services" in its entirety and substituting the following:

   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.

4. The **Limitations and Exclusions** section of Your Contract is amended by deleting the wording of the exclusion regarding "routine physical exam" in its entirety and substituting the following:

   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 Your Contract for:

   1. Mammography Screening;
   2. Well Child Care,
   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.

5. The **Limitations and Exclusions** section of Your Contract is amended by deleting the wording of the exclusion regarding "Medical Social Services" in its entirety and substituting the following:

   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.

6. The **Limitations and Exclusions** section of Your Contract is amended by deleting the wording of the exclusion regarding "Speech and Hearing Services" in its entirety and substituting the following:

   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 Your Contract:

   1. *Extended Care Expense*;
   2. Well Child Care,
   3. Newborn Screening Tests for Hearing Impairment; and
   4. Certain Therapies for Children with Developmental Delays.

Effective January 1, 2006

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1. The **Definitions** section of Your Contract is amended by deleting the definition of "Creditable Coverage" in its entirety and substituting the following:

   Creditable Coverage means coverage under any one of the following:

   a. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;

b. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
   (1) group health insurance coverage;
   (2) individual health insurance coverage; and
   (3) short-term, limited-duration insurance;

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

d. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);

e. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services, and for their dependents);

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

g. A State health benefits risk pool;

h. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);

i. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides heath coverage to individuals who are enrolled in the plan;

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

k. Title XXI of the Social Security Act (State Children's Health Insurance Program.)

Creditable Coverage does not include:

a. Coverage only for accident (including accidental death and dismemberment);

b. Disability income coverage;

c. Liability insurance, including general liability insurance and automobile liability insurance;

d. Coverage issued as a supplement to liability insurance;

e. Workers' compensation or similar coverage;

f. Automobile medical payment insurance;

g. Credit-only insurance (for example, mortgage insurance);

h. Coverage for onsite medical clinics;

i. Limited scope dental benefits, visions benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance;

j. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;

k. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;

l. Medicare supplemental health insurance (as defined under section 1882(g)(1)of the Social Security Act; also known as Medigap or MedSupp insurance);

m. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and

n. Similar supplemental coverage provided to coverage under a group health plan.

2. The **Benefits Provided** section of Your 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. The **Limitations and Exclusions** section of Your Contract is amended by deleting the exclusion regarding "routine physical examinations" in entirety and substituting the following:

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 Your Contract:

1. Mammography Screening;
2. Childhood Immunizations;
3. Certain Tests for the Detection of Prostate Cancer,
4. Newborn Screening Tests for Hearing Impairment;
5. Certain Tests for the Detection of Colorectal Cancer;
6. Certain Therapies for Children with Developmental Delays; and
7. Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer.

Effective September 1, 2006

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1. The **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:

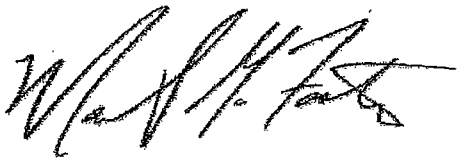
1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability; and
8. Disability.

2. The **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:

   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. The **Standard Provisions** section 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, 2008

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

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, including outpatient day treatment or other post-acute care treatment. This shall include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under this plan who:

  has incurred an Acquired Brain Injury;
  has been unresponsive to treatment; and
  becomes responsive to treatment at a later date.

- Community reintegration services — Services that facilitate the continuum of care as an affected individual transitions into the community, including outpatient day treatment or other post-acute care treatment.

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.

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.

The **Limitations and Exclusions** section of Your Contract is amended by deleting the exclusion regarding "Preexisting Conditions" in entirety and substituting the following:

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 who was continuously covered for an aggregate 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.

If a Participant does not have aggregate Creditable Coverage totaling 18 months, BCBSTX 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 (a) the first day coverage is effective under this Contract, if there is not a waiting period; or (b) the day the applicant files a substantially complete application for coverage, if there is a waiting period.

President of 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 Contract.

Your Contract is amended as follows:

1. The **Benefits Provided** section of Your Contract is amended adding the following new Section, **Use of Non-Contracting Providers**:

   Use of Non-Contracting Providers

   - When you choose to receive services, supplies, or care from ***Hospitals and Facility Other Providers*** not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount) no payment will be made by us.

   - When you choose to receive services, supplies, or care from a ***Physicians, and Professional Other Providers Provider*** that does not contract with BCBSTX (a non-contracting Provider), you receive benefits for covered services that will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Physicians, and Professional Other Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable.** You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan and any applicable Deductibles, Coinsurance Amounts, and Copayment Amounts.

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 not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount)*** – no payment will be made by us.

- *For 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 the Physicians or Professional Other Provider's billed charges or the BCBSTX non-contracting Allowable Amount. The non-contracting Allowable Amount is developed using BCBSTX Allowable Amount data for similar Physicians or Professional Other Providers at a service level identified by standard contracting identification methods. The Allowable Amount for non-contracting Physicians or Professional Other Providers represents the average contract rate for Physicians or Professional Other Providers contracting with us adjusted by a predetermined factor established by BCBSTX and updated on a periodic basis. Such factor shall not be less than 75 % and will be updated not less frequently than once every two years. The non-contracting Allowable Amount does not equate to the Physicians or Professional Other Provider's billed charges and Participants receiving services from a non-contracting Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracting 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 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.

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

Your **Contract**

BlueCross BlueShield
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