Amendment **Booklet**

PPO Select® Advantage

INDIVIDUAL HEALTH COVERAGE

BlueCross BlueShield of Texas

Keeping Texans in a Healthy State

www.bcbstx.com

July 2002

Re: Individual Health Insurance Contract Amendment

Dear Policyholder:

Enclosed you will find an amendment to your current PPO Select® Advantage contract which was effective on your contract renewal date of January 1, 2002. These modifications are briefly outlined below.

During the 2001 Texas Legislative Session, several bills were passed which directly affect your health insurance coverage.

1. Dependent children coverage to age 25,
2. Treatment for acquired brain injuries,
3. Certain tests for the detection of colorectal cancer,
4. Outpatient contraceptive services and devices, and
5. Recognition of a Nurse First Assistant as a protected provider.

In addition to the mandated coverage, corporate changes include revised language for Allowable Amount, organ and tissue transplants, and clarification of benefits subject to the physician office visit and emergency/treatment room copayment amounts.

There has also been a change in the prescription drug benefit. The prescription drug benefit has been updated to now allow up to a 90-day supply on all covered drugs, instead of those few prescriptions that were only eligible subject to certain chronic conditions. Each time you have a prescription order filled or refilled, a copayment amount will apply to each 30-day quantity of the drugs dispensed. This means you will pay three copayment amounts for a 90-day supply. <u>All</u> prescription orders filled or refilled from this point forward will be subject to this amendment.

Please place this amendment with your contract for easy referral. If you have any questions regarding this change or about other benefits available, please contact our customer service unit at 1-800-521-2227 or your insurance agent.

Sincerely,

Select Membership

An Amendment

Effective January 1, 2002

To be attached to and made a part of your Blue Cross and Blue Shield of Texas* PPO Select® Advantage Plan Insurance Contract.

Your Contract is amended as follows:

1. The **Network Benefits, Copayment Amount Chart** is deleted in its entirety.

2. Article I of this Contract is amended by deleting the wording of Section 2 in its entirety and substituting 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 and 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*** – The Allowable Amount will be the amount BCBSTX would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate, the Allowable Amount will be the lesser of billed charge or a per diem established by BCBSTX.

   - ***For procedures, services or supplies provided in Texas by Physicians and Professional Other Providers not contracting with BCBSTX*** – The Allowable Amount will 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.

     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.

   - ***For procedures, services or supplies performed outside of 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 Texas regional or state allowable amounts applicable to procedures, services or supplies of Physicians or Professional Other Providers with similar skills and experience.

   - ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount*plus* one-half of the Allowable Amount *for each* of the other 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 established by BCBSTX and updated on a periodic basis.

- ***For procedures, services or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare's limiting charge.

3. Article I of this Contract is amended by deleting the wording of Section 15 in its entirety and substituting the following:

15. **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.

4. Article I, of this Contract is amended by deleting the wording of Section 38 in its entirety and substituting the following:

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

5. Article I, Section 44 of this Contract is amended by deleting the wording of subsection l in its entirety and substituting the following:

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

6. Article I, Section 44 of this Contract is amended by adding the following new subsections:

Outpatient Contraceptive Services and prescription contraceptive devices. However, coverage for prescription oral contraception medications is provided under the Prescription Drug Program.

Telehealth Service and Telemedicine Medical Service.

7. Article I, Section 52, of this Contract is amended by adding the following Professional Other Provider:

Nurse First Assistant

8. Article I of this Contract is amended by adding the following new definitions:

Compound Drugs means those drugs, which meet the following requirements:

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

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

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.

8. Article III, Section 1, of this Contract is amended by deleting the wording of Subsections a and b in theirentirety and substituting the following:

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

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

9. Article IV, Section 1e(1) of this Contract is amended by deleting the wording of the second sentence in the first paragraph in its entirety and substituting the following:

   In an emergency, precertification should take place within two working days after the admission or as soon as reasonable possible.

10. Article IV, Section 1e(2) of this Contract is amended by deleting the wording of the second sentence of the fourth paragraph in its entirety and substituting the following:

    A letter will be sent to You and the agency or facility confirming precertification or denying benefits.

11. Article IV, Section 1f of this Contract is amended by deleting the wording of Subsections (1)(a) and (1)(b) in their entirety and substituting the following:

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

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

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

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

12. Article IV, Section 1, of this Contract is amended by deleting the wording of Subsection (8) in its entirety and substituting the following:

(8) **Benefits for Emergency Care**

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

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

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

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

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

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

(c) A $75 Copayment Amount will be required for each outpatient Hospital emergency room visit as indicated on Your application for coverage under this Contract. Eligible Expenses for other covered charges provided at the time of the emergency/treatment visit (e.g. facility and Physician charges and lab or X-ray) will be subject to the Deductible and Coinsurance Amounts. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived.

13. Article IV, Section 1m, of this Contract is amended by deleting Subsection (11) in its entirety and substituting the following:

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

(a) Subject to the conditions described below, including the organ and tissue transplant maximum, Network Benefits and Out-of-Network Benefits for covered services and supplies provided to a Participant (donor

and/or recipient) by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if:

i) The transplant procedure is not Experimental/Investigational in nature;
ii) Donated human organs or tissue are used;
iii) The recipient is a Participant under this Contract. Benefits are also available to a live donor to the extent that benefits remain under the recipient's contract after benefits for the recipient's expenses have been provided;
iv) The transplant procedure is precertified as provided in Section 1, Subsection e(3), of this Article IV;
v) The Participant meets all of the criteria established by Us in Our written medical policy guidelines; and
vi) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

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

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

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

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

i) For the evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
ii) For the removal of organs or tissues from deceased donors; and
iii) For the transportation and storage of donated organs or tissues.

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

i) Living and/or travel expenses of the live donor or recipient;
ii) Donor search and acceptability testing of potential living donors;
iii) Expenses related to maintenance of life for purposes of organ or tissue donation; and
iv) Purchase of the organ or tissue.

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

(f) The total amount of benefits for organ and tissue transplants available to any one Participant under this Contract shall not exceed a $250,000 maximum. This maximum shall include benefits provided for prescription drugs used while in the Hospital. Benefits for drugs used on an outpatient basis will be provided under the Prescription Drug Program and will be subject to the Calendar Year maximum benefit amount specified in Article IV, Section 2e, of this Contract.

14. Article IV, Section m, of this Contract is amended by adding the following new Subsections:

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an acquired brain injury:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neuro-physiological, neuro-psychological, and psychophysiological testing or treatment;
- Neurofeedback therapy;
- Remediation;
- Post-acute transition services; and
- Community reintegration services.

Benefits for Certain Tests for Detection of Colorectal Cancer

If a Participant 50 years of age or older and who is at normal risk for developing colon rectal cancer incurs *Medical-Surgical Expense* for a diagnostic medically recognized screening examination for the detection of colorectal cancer, benefits will be determined as described under Preventive Care, except that if the maximum benefit amount has been reached under that provision:

- Such Participant shall receive benefits for a:
  - Fecal occult blood test performed annually and flexible sigmoidoscopy performed every five years; or
  - Colonoscopy performed every ten years, and
- Benefits will be provided as described in the subsection entitled **Benefits for Medical-Surgical Expense.** The Copayment Amount will be required for Network Benefits for Physician office visits. The Calendar Year Deductible will apply to Out-of-Network Benefits.

15. Article IV, Section 2 of this Contract, is amended by deleting the wording of Subsection i in its entirety and substituting the following:

i. **Limitations on Quantities Dispensed**

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

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

16. Article V, Section 1, of this Contract is amended by deleting the wording of Section n, as previously amended, in its entirety and substituting the following:

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

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

17. Article V, Section 1, of this Contract is amended by deleting the wording of subsection t in its entirety and substituting the following:

    t. Any services or supplies for mental or nervous disorders. This exclusion does not apply to the following except as may be provided in this Contract for Organic Brain Disease as defined in Article I, and acquired brain injury as described Article IV, in this Contract, as amended.

18. Article V, Section 1, of this Contract is amended by deleting the wording of subsection v in its entirety and substituting the following:

    v. Except as specifically provided in this Contract, any Medical Social Services; any outpatient family counseling and/or therapy; bereavement counseling; vocational counseling, or any services or supplies provided by a Licensed Master Social Worker-Advanced Clinical Practitioner, Licensed Professional Counselor, or a Marriage and Family Therapist.

19. Article V, Section 1, of this Contract is amended by deleting the wording of subsection ff in its entirety and substituting the following:

    ff. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations or any Retin-A or pharmacologically similar topical drugs.

20. Article V, Section 1, of this Contract is amended by deleting the wording of subsection kk in its entirety and substituting the following:

    kk. Any smoking cessation products requiring a Prescription Order.

21. Article V, Section 1, of this Contract is amended by deleting the wording of subsection nn in its entirety and substituting the following:

    nn. Orthodontic or other dental appliances; splints or bandages provided by a Physician in a non-hospital setting or purchased "over-the-counter" for support of strains and sprains; orthopedic shoes, which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts, except for podiatric appliances when provided in conjunction with treatment of diabetes.

22. Article V of this Contract is amended by deleting the wording of Sections 2a and 2b in their entirety and substituting the following:

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

b. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar device, artificial appliances, or similar devices (except disposable hypodermic needles and syringes for self-administered injections). However, coverage for contraceptive devices is provided under the Medical portion of this Contract.

23. Article V, Section 2, of this Contract is amended by deleting the wording of subsection i in its entirety and substituting the following:

i. Contraceptive devices, non-prescriptive contraceptive materials, (except oral contraceptive medications and contraceptive materials which are Legend Drugs; infertility medications and fertility medications. However, coverage for contraceptive devices is provided under the Medical portion of this Contract.

24. Article V, Section 2 of this Contract is amended by deleting the wording of subsection j in its entirety and substituting the following:

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

25. Article V, Section 2, of this Contract is amended by deleting the wording of subsection m in its entirety and substituting the following:

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

26. Article V, Section 2, of this Contract is amended by deleting the wording of subsection t in its entirety and substituting the following:

t. Any smoking cessation products requiring a Prescription Order.

27. Article VI of this Contract is amended by deleting the wording of Section 2a(2) in its entirety and substituting the following:

(2) Coverage for any unmarried child who is medically certified as Disabled and dependent upon you shall not terminate upon reaching age 25 if the child continues to be both (a) disabled and (b) dependent upon You for more than one-half of his support as defined by the *Internal Revenue Code* of the United States. ***Disabled*** mean any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under this Contract and before the child attains age 25. You must submit proof of the disability and dependency to Us within 31 days following the child's attainment of age 25. As a condition to the continued coverage of a child as a disabled Dependent beyond are 25. We may require periodic or mental condition but not more frequently than annually after the two-year period following the child's attainment of age 25.

28. Article VI of this Contract is amended by deleting the wording of Section 4 in its entirety and substituting the following:

4. Notwithstanding the provision of Section 2, above, within 30 days of a divorce, marriage of a child, or attaining age 25, the former Dependent losing coverage may elect to apply for coverage in his own name.

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

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

Inpatient Stay Following Birth of a Child

For each person covered for maternity/ childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

a. 48 hours following an uncomplicated vaginal delivery; and
b. 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

a. give birth in a hospital or other health care facility; or
b. remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

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

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

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or

(b) a colonoscopy performed every ten years.

BlueCross BlueShield
of Texas

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of Texas

HIPAA NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

We are required by applicable federal and state law to maintain the privacy of your protected health information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect November 10, 2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or other health care provider providing treatment to you. We may use or disclose your PHI to a health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Health care operations include the business functions conducted by a health insurer. These activities may include providing customer services, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the plan sponsor of a group health plan. We may also in our health care operations disclose PHI to business associates[1] with whom we have written agreements containing terms to protect the privacy of your PHI.

[1] A "business associate" is a person or entity who performs or assists Blue Cross Blue Shield of Texas with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules.

We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing health care fraud and abuse.

Joint Operations: We may use and disclose your PHI connected with a group health plan maintained by your plan sponsor with one or more other group health plans maintained by the same plan sponsor, in order to carry out the payment and health care operations of such an organized health care arrangement.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

Personal Representatives: We will disclose your PHI to your personal representative when the personal representative has been properly designated by you and the existence of your personal representative is documented to us in writing through a written authorization.

Disaster Relief: We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Health Related Services: We may use your PHI to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities. We may use or disclose your PHI to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA-regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to avert a serious threat to health or safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by and to the extent necessary to comply with state worker's compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization; and
- in connection with certain research activities.

Use and Disclosure of Certain Types of Medical Information: For certain types of PHI we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide by the following rules for our use or disclosure of certain types of your PHI:

- *HIV Test Results.* We may not disclose the result of any HIV test unless required by law or the disclosure is to you, your personal representative, a physician or other person who ordered the test, or a health care worker who has a legitimate need to know the results of the test for safety purposes; or pursuant to an authorization signed by you providing us permission to disclose to an insurance medical

information exchange, a reinsurer, or to our attorneys.

- *Genetic Information.* If any genetic test information is included in claims or records we receive, we may not use or disclose your genetic information unless the use or disclosure is authorized by law or you provide us with written permission to disclose such information.
- *Status as Victim of Family Violence.* We may not disclose your status as a victim of family violence unless the disclosure is to you; to a physician or health care provider for the provision of health care services; to a licensed physician designated by you; as required by law or pursuant to an order of the Texas Insurance Commissioner or a court order; to our attorneys; or when necessary for our payment and health care operations if to a reinsurer, a party to a sale of all or part of our business or to medical and claims personnel we contract with, providing we cannot without undue hardship first segregate the medical information in a way that does not disclose your status as a victim of family violence.
- *Mental Health Information.* We may not disclose your mental health information except for the same purposes for which we received the information or as may be required by law.
- *Confidential Communications from a Physician.* We may not disclose confidential information about you that we receive from a physician for any purpose other than for which we received the information or as may be required by law.
- *Medical Information We Receive While Performing Utilization Review.* If we collect or receive your medical information while performing utilization review activities, we may not disclose that information unless the disclosure is required by law or to an individual or entity that we have contracted with to aide us in performing utilization review.

Individual Rights

You may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

Access: You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. A "designated record set" contains records we maintain such as enrollment, claims processing, and case management records. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI and may obtain a request form from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Disclosure Accounting: You have the right to receive a list of instances for the 6-year period, but not before April 14, 2003 in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, health care operations, or as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fee structure at your request.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

Confidential Communication: You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your

request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting the Privacy Office or by using our website, **www.bcbstx.com**. If you receive this notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

Questions and Complaints

If you want more information about our privacy practices of have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, you may complain to using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services; see information at its website: www.hhs.gov. If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Director, Privacy Office
Blue Cross Blue Shield of Texas
P.O. Box 804836
Chicago, IL 60680-4110

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

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

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 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

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.

An Amendment

Effective January 1, 2011

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

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

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

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

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

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

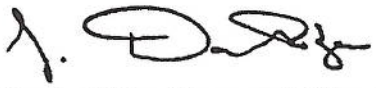
   Rescission of Coverage: Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on the Participant's application, will result in the cancellation of Your coverage (and/or Your Dependent(s) coverage) retroactive to the Effective Date, subject to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

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

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

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

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



President of Blue Cross and Blue Shield of Texas

NOTICE

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

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

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

An Amendment

Effective January 1, 2006 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: _____

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

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

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

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

   Allowable Amount

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

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

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

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

   - ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

   - ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount)*** – The Allowable Amount will be the lesser of: (i) the Provider's billed charges, or; (ii) the BCBSTX non-contracting Allowable Amount. Except as otherwise provided in this section, the non-contracting Allowable Amount is developed from base Medicare Participating reimbursements adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

     Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for

duration and adjusted by a predetermined factor established by BCBSTX. Such factor shall be not less than 75% and shall be updated on a periodic basis.

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

BCBSTX will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non-contracted Providers which may also alter the Allowable Amount for a particular service. In the event BCBSTX does not have any claim edits or rules, BCBSTX may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Amount will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by BCBSTX within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

The non-contracting Allowable Amount does not equate to the Provider's billed charges and Participants receiving services from a non-contracted Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracted Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back your BCBSTX Identification Card.

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

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

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

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

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For Insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued.)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. 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:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for any one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and 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 Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov

BlueCross BlueShield of Texas

Value-added programs, tools and services are just another advantage of being a Blue Cross and Blue Shield of Texas (BCBSTX) member.

Blue Access for Members℠*

Your gateway to health information

It's easy to register and find what you need at ***bcbstx.com/member.***

When it comes to managing your health information, it's "easy does it" with our Blue Access for Members (BAM) member site. BAM gives you important health and benefits information that you can manage in one convenient place online.

Go to bcbstx.com, click "Log In" and register to access:

- your personal health history
- benefits highlights, claims, explanations of benefits and forms
- health and wellness resources
- special member discounts and programs

Blue Access Mobile℠

With Blue Access Mobile, you have access to real-time claims status, ID cards and coverage details. Now you can get that information while on the go because BAM is mobile!

** Blue Access for Members is not available on child only policies.*

Provider Finder

Easily search for physicians, specialists and hospitals

It's easy to find physicians, specialists and hospitals with the online Provider Finder. Follow these three steps:

1. Visit bcbstx.com
2. Click Provider Finder
3. Search by network, doctor, hospital or area to find the most up-to-date listing of health care providers

Download the free Provider Finder® App for Android or iPhone

In addition to finding a provider when you're on the go, this app can perform a GPS search and get directions to the provider's location.

52157.0413

Well onTarget℠

Motivation and guidance on the path to health and wellness

The Well onTarget program offers an expanded array of personalized tools and resources designed to plan, engage, motivate, sustain and measure, with the end goal of delivering the best wellness experience to members.

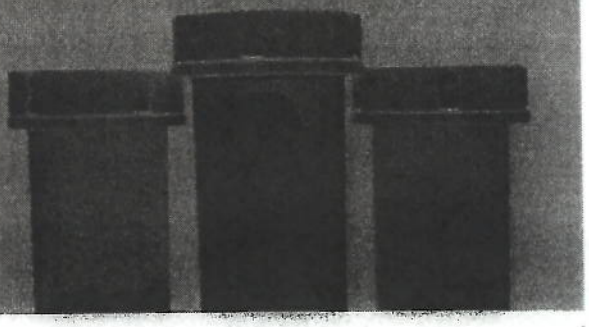
Well onTarget includes wellness programs such as:

- Onmyway™ health assessment
- Health and wellness content
- Liveon wellness member portal
- Fitness program and incentives
- Onmytime self-directed courses

Learn more at wellontarget.com.

Mail service for prescriptions

It's all about convenience



As a BCBSTX member, you have a mail-service prescription drug program available for your maintenance medications. This benefit saves you time and money. Members pay a copayment, coinsurance or a combination, depending on their plan. Just ask your doctor for a written prescription for up to 90 days for each medication you want delivered to your home. You can find more information on BAM under the **My Coverage** tab.

If you have any questions about cost or benefit coverage, call the Blue Cross and Blue Shield Pharmacy Line at 800-423-1973, Monday through Friday, 7 a.m. to 11 p.m., and Saturday and Sunday 7:30 a.m. to 8 p.m. CT. Have your Blue Cross and Blue Shield ID card handy when you call.

Blue365®

Member discount program

Blue365 is just one more advantage of being a BCBSTX member. With this program, you can save money on health care products and services that are most often not covered by your benefit plan. There are no claims to file and no referrals or pre-authorizations.

You can sign up for Blue365, our member discount program that offers deals from brands like Reebok, Jenny Craig® and Nutrisystem®. Log in to Blue Access for Members or visit ***www.Blue365Deals.com/BCBSTX/***.

Davis Vision℠ and TruVision
888-897-9350 or 877-882-2020

Save on eyeglasses as well as contact lenses, laser vision correction services, examinations and accessories. Find out more when you log in to BAM. For a list of Davis Vision providers near you, go to bcbstx.com, click Find a Doctor, then select Find a Vision Provider. The Davis Vision network has major national and regional retail locations as well as independent ophthalmologists and optometrists. You and your eligible dependents can receive discounts on laser vision correction services through the TLC/TruVision network.

Jenny Craig®
877-JENNY70 (877-536-6970)

Jenny Craig can help you reach your weight loss goals. You will get one-on-one support from a trained weight loss expert. Your consultant will give you a tailored program based on the basic components of successful weight management: food, body, mind. You can meet with your consultant in person at a local center. Or you can enjoy the ease of the Jenny Craig At Home program. To get a special savings coupon, log in to BAM.

Life Time® Fitness

Life Time Fitness offers a total health fitness experience no matter your fitness level, interests, schedule or budget. For new members, Life Time Fitness offers a $0 enrollment fee when you sign up online.* Log in to BAM and access the Life Time Fitness website to find a free, seven-day pass to try out the location nearest you.

Procter & Gamble (P&G) Dental Products
877-333-0121

Get savings on dental packages containing the latest in Oral B® power toothbrushes and Crest® products. The dental packages from P&G can help you improve the health of your teeth and gums. Packages may contain items such as an electronic toothbrush, mouth rinse, floss, and many more. To shop in the P&G estore, log in to BAM and click on Member Discounts under Quick Links.

** Proof of Blue Cross and Blue Shield of Texas coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at www.Blue365Deals.com/BCBSTX/. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may change at any time. Offer expires September 1, 2013. Other rules may apply. Always check with the Life Time Fitness club in your area for the most up-to-date offer. Offer not available in Minnesota.*

The relationship between these vendors and Blue Cross and Blue Shield of Texas (BCBSTX) is that of independent contractors.

Blue365 is a discount program only for BCBSTX members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSTX does not guarantee or make any claims or recommendations about the program's services or products. You may want to talk to your doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

Travel with confidence

You're covered!

With our BlueCard® PPO Program, Blue Cross and Blue Shield (BCBS) Plans across the country work together to ensure you receive reliable, affordable health care whenever you're away from home. When you use BlueCard PPO network providers (even while traveling outside your local Plan service area), you will receive the network benefits available through your health plan.

So, when you need medical services outside your local Plan service area, call the customer service telephone number on the back of your ID card. Or call the BlueCard Access telephone number at 800-810-BLUE (2583). The "suitcase" logo on your ID card tells providers that you are part of the BlueCard PPO Program.

Learn more about taking care of your health

Facebook
facebook.com/bluecrossblueshieldoftexas

Twitter
twitter.com/bcbstx

YouTube
youtube.com/bcbstx

Prescription Drug Claim Form

See instructions on reverse.

BlueCross BlueShield of Texas

Patient Information

ID Number

Group Number –

Date of Birth / / ❑ Male ❑ Female

Patient Name (First, Last)

Street Address

City State ZIP

Patient's Relationship to Subscriber/Member:

❑ Self ❑ Spouse ❑ Dependent

I certify that the information is correct and that the patient indicated above is eligible for benefits. I have received the medications described herein and authorize release of all information contained on this claim form to Prime Therapeutics. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

I understand that Blue Cross and Blue Shield of Texas use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical or pharmacy providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996). Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Patient/Subscriber/Member or Legal Representative Signature

Is this medication for an on-the-job-injury? ..... ❑ Yes ❑ No

Do you have other insurance for prescription medications? ..... ❑ Yes ❑ No

If yes, please provide Name of other Insurance:

Policy Number:

Please include any pharmacy receipts related to this claim with this form.

Subscriber/Member Information

Name (First, Last)

Pharmacy Information

Pharmacy Name

Pharmacy Address

City State ZIP

Prescription Claim Information

Original pharmacy receipts are required. Please attach receipts to space provided on the back of form. If receipts are not included, please have pharmacist complete and sign the bottom of this form.

Was this prescription medication purchased outside the U.S.A.? ..... ❑ Yes ❑ No

All fields below must be completed.
(Example on back of form.)
Call your pharmacist if you need assistance.

1 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost $.

Balance Due $.

2 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost $.

Balance Due $.

3 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost $.

Balance Due $.

X

Signature of Pharmacist or Representative (Required only if original pharmacy receipts are not included.) Date

Pharmacy/Prescription Information

1. Use a **separate claim form** for each patient. All information provided on or attached to this claim form must be for the same patient.
2. Tape or glue pharmacy receipts in the spaces provided. When you tape or glue your receipts, it is not necessary for the receipts to fit exactly within the spaces provided. If the taped or glued receipts overlap each other, be sure that all information on each receipt is readable. Each receipt must show:
   - Patient Name
   - Pharmacy Name/Address
   - Total Charge
   - Drug Name and NDC Number
   - NPI Number
   - Quantity
   - Fill Date
   - Rx Number
   - Days Supply

   If any of your receipts do not have **required** information, ask your pharmacist to provide you with the missing information.

   Write that information on your receipt(s). If not completed, the claim will be sent back for the required information.
3. Call the customer service number on your ID card if you have any questions.
4. Have your pharmacist call 800.821.4795 if he/she has any questions.
5. Send completed form to:

   Prime Therapeutics
   P.O. Box 14624
   Lexington, KY 40512-4624

EXAMPLE
of how to complete the Prescription Drug Claim Form.

1 Rx Number: 0 0 0 0 0 6 0 1 1 4 8 1

Date Filled: 0 1 / 1 2 / 0 5

Quantity: 30 Day Supply: 3 0

Name of Medication: "Drug Name"

NDC Number: 0 0 1 2 3 4 5 6 7 3 1
(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number: 9 2 1 5 2 4 1 1 6 3

Prescription Cost: $ 2 0 5 . 1 4

Balance Due: $ 2 0 5 . 1 4

Is this prescription claim for a compound medication?
❑ Yes ❑ No

Note: If yes, make sure your pharmacist completes the information below.

Compound Information:
If a compound prescription, please enter all information per drug used.

Compound Prescriptions
For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1

Pharmacy Receipts Only

Tape or glue one pharmacy receipt in this space.
If you prefer, staple your receipts to the top of this form.

Keep a copy of your receipt(s) for your records.

Rx 2

Pharmacy Receipts Only

Tape or glue one pharmacy receipt in this space.
If you prefer, staple your receipts to the top of this form.

Keep a copy of your receipt(s) for your records.

Fraud Prevention Regulation: Any person who knowingly and with intent to defraud any health plan or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent health plan act, which is a crime and subjects such person to criminal and civil penalties.

Prime Therapeutics LLC is an independent limited liability company providing pharmacy benefit management services.

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

BlueCross BlueShield of Texas

To Use or Disclose Protected Health Information (PHI)

Standard Authorization Form

I. Individual (Name and information of person whose protected health information is being disclosed):

Name			Date of Birth
Group #	Identification/Subscriber #		Social Security Number
Address	City	State	ZIP
Area Code & Telephone Number			

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Texas to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information		Relationship	Purpose
Address	City	State	ZIP

III. Specific Description of Information to be Used or Disclosed

(Please complete Parts A and B in this Section) **This Authorization CANNOT be used to disclose Psychotherapy Notes.**

A. Release of *Sensitive* Protected Health Information Under State Law

You *must* check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to

(note: "yes" means this information is included in the categories you designate in Part B below):

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome;
- Sexually transmitted or communicable diseases (includes hepatitis, as well as venereal diseases);
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

Yes ☐

No ☐

B. Release of Protected Health Information *(check one or more)*

		Dates of Services From:	To:
☐ **Health Plan Benefit Information**	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).		
☐ **Claims**	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc.).		
☐ **Service Determination Information**	Includes any information related to pre-service, concurrent and post-service decisions.		
☐ **Premium**	Includes information related to billing cycles, bank draft changes, etc.		
☐ **Services from (provider or supplier)**	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)		
☐ **Other**	_____ (Specify other information that is not listed in one of the categories above.)		

IV. Expiration and Revocation

Expiration: This authorization will expire on (must choose one):

☐ **One year from the date it is signed** ☐ **Other (insert date or event):** _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Signature **Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of documents if they are already on file with Blue Cross and Blue Shield of Texas.

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____ _____ _____

Personal Representative's Address **City** **State** **ZIP**

_____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

1. **MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR**
2. **COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED**

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Texas
P.O. Box 3238
Naperville, IL 60566-7238

If you need assistance completing the form, please contact our Member Service Department at 1-888-697-0683.

Texas Department of Insurance Notice

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

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

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

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

- *If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: www.tdi.texas.gov/consumer/cpmmediation.html.*

An Amendment

January 1, 2012

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

AMENDMENT TO THE CONTRACT

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

Premium Rebates and Premium Abatements:

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

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

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

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

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

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

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

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

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

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

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

President of Blue Cross and Blue Shield of Texas

An Amendment

Effective Date September 1, 2011

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

Your Contract is amended as follows:

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

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

Benefits for Orally Administered Anticancer Medication

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

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

President of Blue Cross and Blue Shield of Texas

PPO Select® Advantage

Benefit Guide

Your Health Care Benefits

BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.

PPO Select Advantage from Blue Cross and Blue Shield of Texas is health care coverage specially designed for individuals and their families. When you go to BlueChoice® network providers, you will maximize your benefits and usually pay less for care. This benefits guide provides you with instructions and tips to get you started. If you need more information, please call Member Service toll-free at 1-888-697-0683.

This guide summarizes certain provisions of the *PPO Select Advantage* plan. Complete details of the plan are included in the contract. If there is a difference between this booklet and the contract, the contract will govern.

What is PPO Select Advantage?

Overview

This section provides information on *PPO Select Advantage* health care coverage from Blue Cross and Blue Shield of Texas (BCBSTX). This information is intended to provide you with the knowledge necessary to understand and use *PPO Select Advantage* benefits.

General Information

As a *PPO Select Advantage* member, you will:

- have the freedom to choose a doctor each time you need care
- have access to one of the largest provider networks in Texas, the BlueChoice® network
- not have to file claim forms when using network providers
- have the protection of the Blue Cross and Blue Shield of Texas ID card, one of the most recognized health care ID cards in the nation

About the BlueChoice Network

BCBSTX has contracted with medical professionals in the BlueChoice network to provide you with cost-effective, quality health care. These network providers will help make sure you get care that's right for you. It's a good idea to choose a doctor from the network who can get to know you and your medical history. By seeing a network provider for care, you will pay less, generally not file claims and you'll get your plan's highest level of benefits for covered services.

Receiving Care

When you need medical care, make an appointment with a Blue Choice network provider. At the time of your appointment, show your BCBSTX member ID card and pay your copayment. After your office visit, you won't need to file claims or pre-authorize care because your network provider should take care of that for you. You may choose to use any licensed doctor for your care, but if you do not use a BlueChoice network provider, you will receive a lower level of benefits and your out-of-pocket cost usually will be higher.

Questions

This booklet highlights your *PPO Select Advantage* coverage and is designed to help you understand your benefits. If you have questions after reviewing this guide call Member Service toll-free (888)697-0683. or visit our Web site at www.bcbstx.com.

Network vs. Out-of-Network Benefits - Section 2

Summary
The amount of benefits paid by your *PPO Select Advantage* coverage depends on whether or not you receive your medical care through the network. In general, you pay less when you receive covered benefits from a network provider. You will always have a right to choose, but the choice you make can save you money.

Network
Your network coverage begins with your selection of a BlueChoice network provider. When you see a BlueChoice provider, you will:

- pay less for care
- receive this plan's highest level of benefits
- have no claims to file
- have network providers pre-authorize your care

Out-of-Network
If you decide to go out-of-network or are not in a service area for medical care, you have two choices:
- see a ParPlan contracted provider
- see any licensed provider

ParPlan contracted providers and facilities have agreed to accept the BCBSTX determined Allowable Amount and/or negotiated rates for covered services. Costs are more predictable, since you will not be balance billed for costs that may exceed the Allowable Amount. ParPlan providers may file your claims. You will, however, receive out-of-network benefits.

Or, if you prefer, you may use any licensed provider who's not participating in the BlueChoice® network. With this choice you will:
- receive a lower level of benefits
- pay a greater share of the costs
- file your own claims.

Pre-authorization - Section 3

About Pre-authorization
Your *PPO Select Advantage* plan requires pre-authorization for all inpatient hospital admissions, extended care, home infusion therapy, and organ and tissue transplants. Pre-authorization helps ensure that your hospital stay is medically necessary and protects you from unnecessary procedures.

Points to Remember
You are responsible for pre-authorization.

Failure to pre-authorize your care before it is received results in:

- **$250 penalty for in-hospital stays**
- **50% penalty (up to $500) for extended care and home infusion therapy services**
- **your claim may be denied, if it is determined to be not medically necessary**

How to Pre-authorize
To pre-authorize, you, your physician, the hospital, or a family member must call the toll-free number listed on the back of your ID card. A nurse will work with your physician's office to complete the pre-authorization process. It can usually be taken care of with just one phone call.

In an Emergency
When a medical emergency occurs, there is seldom time to pre-authorize a hospital admission. Have someone call to authorize your stay within two days after you are admitted. Pre-authorization calls made after business hours are recorded and returned the next business day.

Call
To pre-authorize, call toll-free:
(800) 441-9188 or
(972) 783-4475 in Dallas
8 a.m. to 8 p.m.
Monday through Friday

What To Do in an Emergency - Section 4

Emergency Care
Emergency care for life-threatening or severe medical conditions is covered 24-hours a day, seven days a week, both inside and outside your network service area.
- All treatment received during the first 48-hours following a medical emergency will be eligible for network benefits. After 48-hours, network benefits will be available only if you use network providers.
- A deductible and coinsurance is required for facility charges for each outpatient emergency room visit. The copayment will be waived if you are admitted to the hospital for the emergency condition immediately following the visit.

Emergency Care means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

In the event of an emergency, you should do one of the following:
- If reasonably possible, contact your network provider before going to the hospital emergency room.
- If not reasonably possible to contact your network provider, go to the nearest emergency facility, whether or not the facility is a network provider.
- Contact your network provider within 48 hours, or as soon as reasonably possible.
- If hospitalization is necessary, the admission must be authorized within two working days, or as soon as reasonably possible.

Remember: If an emergency occurs, call 911, your local ambulance, or go to the nearest emergency room.

Prescription Drug Program for PPO Select Advantage - Section 5

To help manage increasing prescription drug costs, Blue Cross and Blue Shield of Texas' pharmacy drug program encourages cost-effective drug selection while offering financial flexibility to members.

By using generic medications or drugs on the preferred brand-name drug list, you will be able to obtain those medications that are high quality and cost effective. Benefits will be available for nearly all branded prescription drugs, with generic medications having the lowest copay and non-preferred brand-name drugs have the highest copay.

How it works:

When you receive your prescriptions, the pharmacist will fill it with generic drugs, if available unless your doctor indicates "Dispense as Written" (DAW) on the prescription.

- If your doctor indicates DAW on the prescription you pay the copay for the brand-name drug
- If your doctor does not indicate DAW on the prescription and you elect to purchase a brand-name drug, you pay the copay for the brand-name drug, plus the cost difference between the generic and brand name drug.
- If no generic drug is available, you pay the copay for the brand-name drug

Find a participating pharmacy close to your home or work. To locate the network pharmacy nearest you, call Member Service toll-free at (888) 697-0683 or visit our Web site at www.bcbstx.com and click on ProviderFinder®.

Remember, to save money on prescriptions – ***Go Generic!***

The program includes three tiers of medications:

Generic drugs – These are the most affordable drugs and offer members the lowest available copay. Generic drugs are pharmaceutically and therapeutically equivalent to brand-name drugs.

Preferred brand-name drugs – You will pay a slightly higher copay with preferred brand-name drugs than with generic drugs, but this tier consists of the vast majority of high-quality branded drugs on the market.

Non-preferred brand-name drugs – The highest copay is required when selecting the non-preferred brand-name drug tier. Non-preferred brand-name drugs may not offer clinical or cost advantages over other drugs in the same therapeutic category.

A list of preferred brand-name drugs is available on the Blue Cross and Blue Shield of Texas Web site at www.bcbstx.com/pharmacy.

Mail Order Prescription Drug Program

You may obtain up to a 90-day supply of your covered prescription drug for two copay amounts. Mail order drug expenses are included in the $1,500 calendar year prescription drug maximum.

Making a Change - Section 6

The following administrative changes should be reported by providing the new information on a Miscellaneous Change Form:

Changing Name/Address

Name Change
- Must give reason for the change
- New bank draft authorization form and blank check marked "VOID" required if using bank draft method to pay premiums

Address Change

A change in address may result in:
- A change in premium
- Termination of coverage if the permanent residence is outside the state of Texas

Any change in premium will occur on the first of the month following the receipt of a change in address. If that date is before the next premium due date, BCBSTX will bill or credit premium from the date of change to the next premium due date on the following bill.

Adding or Deleting Dependents

Add
- Evidence of Insurability required (may not apply to newborns, see below - **"Adding Newborns"**
- If approved, coverage will be effective on the first of the month following underwriting approval

Delete
- Deletion effective on the first of the month following receipt of the Miscellaneous Change Form

Adding Newborns
- Automatic coverage for first 31 days of the child's life
- No Evidence of Insurability is required if coverage is applied for within 31 days of the child's date of birth
- Dependent premium is charged from the date of birth
- Adopted newborns are eligible for coverage after a Miscellaneous Change Form is completed and approved for coverage by Medical Underwriting. If approved, the coverage will be effective on the first of the month following underwriting approval.

Adding Court Mandated Dependents

To add coverage for a court mandated dependent, submit:
- Miscellaneous Change Form
- Copy of legal document mandating coverage

Notes
- Although eligible court mandated dependents are guaranteed coverage, they are evaluated by Medical Underwriting and coverage may be issued with condition riders. Coverage is guaranteed only if all the required documentation (above) is received within 31 days following the date of the court order.
- If all documentation is received within 31 days, coverage will be effective on the date of the court order.
- If all documentation is not received within 31 days, the dependent is subject to Medical Underwriting approval. If approved, the coverage will be effective on the first of the month following underwriting approval.

Changing Deductible
- Increases allowed without Evidence of Insurability
- Decreases require medical underwriting and approval by BCBSTX
- All deductible changes become effective on the first of the month following receipt or underwriting approval (when required)
- New deductible applies to all claims incurred on or after the effective date of the change

Canceling Coverage
- Written notification required
- Coverage, including all dependent coverage, terminates on the last day of the month in which the written request is received by BCBSTX.

Typical Questions and Answers - Section 7

What if my regular doctor isn't in the BlueChoice network?
You can still see your non-network provider, but you will receive out-of-network benefits for covered services.

What do I do when I'm on vacation and need medical care?
Your *PPO Select Advantage* plan covers you whether you are at home or away. If it is an emergency, seek care immediately. In non-emergencies, call Customer Service to identify a BlueChoice provider to receive network level benefits. Outside of Texas, you will receive the out-of-network level of benefits for covered services.

What happens if I go to a ParPlan provider instead of a BlueChoice network provider?
You will receive out-of-network benefits, including paying twice the network deductible. ParPlan providers offer cost advantages by agreeing to accept the BCBSTX contracted Allowable Amount for covered services and may file your claims.

What does my office visit copayment cover?
When you go to BlueChoice network providers for your health care, your copayment covers routine office visits/consultations only. All other services such as laboratory services or x-rays are subject to your deductible and coinsurance.

Do I need a referral to see a specialist?
No. You can see any licensed provider you choose. However, it is to your advantage to use a BlueChoice network provider to receive your program's highest level of benefits.

What if my doctor refers me to a specialist or lab that is not in the BlueChoice network?
You will receive benefits at the out-of-network level. In order to receive the highest level of benefits, you must see a BlueChoice network provider. Your directory lists all BlueChoice doctors, specialists, hospitals, labs, and other facilities in the network. You should ask your doctor to refer you to a BlueChoice network provider.

What if my doctor is listed in the BlueChoice directory, but the office I want to go to is not listed?
You should verify that the provider you select is a BlueChoice network provider at the location where you want to receive care. If the location has not contracted to be in the BlueChoice network, you will receive benefits at the out of-network level for covered services.

What if I have an appointment to see my BlueChoice doctor but, his/her assistant sees me instead?
If the assistant is a BlueChoice network physician, you will receive the in-network level of benefits. However, if the assistant has not contracted with BCBSTX to be in the BlueChoice network, you will receive out-of-network benefit levels. Ask your doctor who else in the office is a BlueChoice network provider.

Do I need a referral to see a specialist?
No. You can see any licensed provider you choose. However, it is to your advantage to use a BlueChoice network provider to receive your program's highest level of benefits.

Numbers to Remember - Section 8

The following numbers can provide you with answers to your *PPO Select Advantage* questions:

Service	Numbers to Remember
Member Service Benefits or Claims Questions	Toll-free: 1-888-697-0683 Hours: 8 a.m. to 8 p.m., CST Monday-Friday
Visit our Web site to find a BlueChoice network provider	www.bcbstx.com

Information and brochures for all our individual products can be obtained through one of our independent agents authorized to sell BCBSTX products, BCBSTX Consumer Markets, or directly from our Web site.

Visit our Web site at:
www.bcbstx.com

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

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

NOTICE OF TEN-DAY RIGHT TO EXAMINE CONTRACT

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

Blue Cross and Blue Shield of Texas*

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

Has issued this individual

PREFERRED PROVIDER CONTRACT

providing

Comprehensive Major Medical Expense Coverage

to

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

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

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

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

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

President

[redacted]

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

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IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-888-697-0683

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

P. O. Box 2035
Aurora, Illinois 60507-2035

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

1-800-252-3439

- You may write the Texas Department of Insurance at:

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

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

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-888-697-0683

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

P. O. Box 2035
Aurora, Illinois 60507-2035

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

1-800-252-3439

- Puede escribir al Departmento de Seguros de Texas:

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

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

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

NETWORK BENEFITS
MEDICAL SERVICES
COPAYMENT AMOUNT CHART

OFFICE SETTING SERVICES	COPAYMENT
Allergy Injections (billed with the office visit)*	100% after Copay
Allergy Tests	100% after Copay
Certain Outpatient Procedures	Coinsurance after Deductible
Chemotherapy	100% after Copay
Consultation	100% after Copay
Dental Exam (Accident within the first 48 hours)	100% after Copay
Hearing Exam Office Visit Charge**	100% after Copay
Immunizations – birth through age 7	100%
Independent Lab	100%
Injections (Except Allergy Injections)	100% after Copay
Lab – Office	100% after Copay
Occupational Modalities in Conjunction with Physical Therapy**	Coinsurance after Deductible
Office Visit	100% after Copay
Office Surgery	Coinsurance after Deductible
Physical Therapy**	Coinsurance after Deductible
Radiologist	100%
Routine Immunizations (age 8 and over), Lab, X-Ray, & Hearing Test**	100% after Copay
Routine Physical Exam Office Visit Charge**	100% after Copay
Speech Therapy	100% after Copay
Supplies	100% after Copay
Vision Exam**	100% after Copay
Well Baby Exam Office Visit Charge**	100% after Copay
X-Ray - Office	100% after Copay

* When billed separately, medical/surgical coinsurance plus any applicable Deductible.
** Subject to days or dollar maximums

NOTE: Services requiring a return office visit, for example, lab/x-ray, on a different day will require a new Copayment

Article I — Definitions

As used in this Contract:

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

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

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

   b. For Hospitals and Facility Other Providers not contracting with Us, Allowable Amount shall be the lesser of billed charges or a per diem determined by averaging the pre-established per diem for Hospitals in the same geographical area. For those Facility Other Providers for which a per diem payment methodology is not appropriate, Allowable Amount shall be the lesser of billed charges or the amount We would have considered for payment for the same procedure, service, or supply at an equivalent Facility Other Provider in the same geographical area based on payment methodologies that may include diagnosis related grouping (DRG), relative value, resource based relative value scale (RBRVS).

   c. For procedures, services or supplies provided in Texas by Physicians and Professional Other Providers not contracting with Us, Allowable Amount shall be the lesser of the billed charge or the amount We would have considered for payment for the same covered procedure, service or supply if performed or provided by a Physician or Professional Other Provider with similar experience and/or skill in the same locale, as determined by Us from data We have compiled.

      If We do not have sufficient data to calculate the Allowable Amount for a particular procedure, service or supply, We will determine an Allowable Amount based on the complexity of the procedure, service or supply and any unusual circumstances or medical complications specifically brought to Our attention, which require additional experience, skill and/or time.

   d. For procedures, services or supplies performed outside of Texas by Physicians or Professional Other Providers not contracting with Us, or any other Blue Cross and Blue Shield Plan, We will establish an Allowable Amount using, at Our option, 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.

   e. 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.

   f. For drugs administered by a Home Infusion Therapy Provider, the Allowable Amount will be the lesser of (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up. 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.

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

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

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

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

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

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

   c. Skin irritation by Rinkel method; or

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

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

7. **Complications of Pregnancy** means:

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

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

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

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

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

11. **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.

12. **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.

13. **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)).

k. Short-term limited duration coverage.

Creditable Coverage does not include:

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

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

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

(4) Workers' Compensation or similar insurance;

(5) Credit-only insurance;

(6) Coverage for onsite medical clinics;

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

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

(9) Coverage for a specified disease or illness;

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

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

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

(13) Automobile payment insurance

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. A Subscriber's spouse; or

b. Any unmarried child who is under 23 years of age; or

Child means:

(1) The natural child of the Subscriber; or

(2) A legally adopted child of the Subscriber (including a child for whom the Subscriber is a party in a suit in which the adoption of the child is being sought); or

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

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

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

16. **Diabetic Equipment and Supplies** means those Medically Necessary 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:

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

(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,

(6) Syringes,

(7) Prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and

(8) Glucagon emergency kits.

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 Article IV, Section 1 of this Contract.

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

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

    b. Serious impairment to bodily functions,

    c. Serious dysfunction of any bodily organ or part,

    d. Serious disfigurement, or

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

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 nonorganic, 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.

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

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

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. **Generic Substituted Drug** means a drug, which costs less than the brand name drug prescribed but is therapeutically equivalent to the brand name drug prescribed.

25. **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.

26. **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.

27. **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.

28. **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.

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

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

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

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

31. **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.

32. **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.

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

    Bed patient means confinement in a bed accommodation located in a portion of a Hospital which is designed, staffed and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of he Hospital designed, staffed and operated to provide long-term institutional care on a residential basis.

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

35. **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.

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

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

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

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

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

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

39. **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.

40. **Maximum Allowable Cost (MAC)** means the maximum cost for which We will reimburse a Participating Pharmacy for selected products.

41. **Maximum Allowable Cost (MAC) List** means a list of approximately 80% of the most commonly dispensed drugs that have generic equivalents. Only products rated therapeutically equivalent by the U.S. Food and Drug Administration (as most recently published) are included.

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

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

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

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

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

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

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

    Medical-Surgical Expense shall include:

    a. Services of Physicians or Professional Other Providers.

    b. Services of a certified registered nurse-anesthetist.

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

d. Diagnostic x-ray and laboratory procedures.

e. Radiation therapy.

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

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

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

(2) Home air-fluidized bed therapy.

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

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

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

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

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

l. Prosthetic Appliances 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.

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

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

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

p. Diabetic Equipment and Supplies, including but not limited to, prescription orders for insulin, insulin analogs, prescriptive and nonprescriptive oral agents for controlling blood sugar levels. Insulin analogs, syringes necessary for self-administration, prescriptive and nonprescriptive oral agents will be covered under the Prescription Drug Program.

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

a. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and

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

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

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

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

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

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

48. **Network Physician** means a Physician or Professional Other Provider who has executed a managed care agreement with Us for the provision of health care to Participants covered under this Contract.

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

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

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

    b. Incision and drainage of facial abscess;

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

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

51. **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.

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

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

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

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

        (1) Advanced Practice Nurse
        (2) Doctor of Chiropractic
        (3) Doctor of Dentistry
        (4) Doctor of Optometry
        (5) Doctor of Podiatry
        (6) Doctor in Psychology
        (7) Licensed Audiologist
        (8) Licensed Occupational Therapist
        (9) Licensed Physical Therapist
        (10) Licensed Speech-Language Pathologist
        (11) 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.

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

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

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

56. **Participating Pharmacy** means an independent Pharmacy or chain of Pharmacies which has entered into an agreement to provide prescription drug services.

57. **Pharmacy** means:

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

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

58. **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.

59. **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*.

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

61. **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.

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

63. **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.

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

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

66. **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.

67. **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.

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

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

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

69. **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.

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

71. **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.

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

Article II — Effective Date of Dependent Coverage

1. **Newborn Child**

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

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

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

2. **Court Ordered Coverage for Dependents**

   If You are required to provide coverage for a minor child as a result of a medical support order issued under the requirements of Section 14.061, Family Code, coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage beyond 31 days, You must make application for coverage on a form approved by Us and pay the required premium within that 31-day period. If We receive notification after the 31-day period, coverage shall be contingent upon the Subscriber's making application for such coverage on a form approved by Us. The application form and satisfactory evidence of insurability must be submitted to Us at Our Administrative Office. Subject to Our approval of the application, evidence of insurability, and payment of the first full month's premium, coverage shall become effective of the first day of the Contract Month following the date We approve the application.

3. **Other Dependents**

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

   b. Coverage for a Dependent (other than a newborn child or a court ordered child) of a Subscriber already having coverage under this Contract shall be contingent upon You making application for such coverage on a form approved by Us. The application form and satisfactory evidence of insurability must be submitted to Us at Our Administrative Office. Subject to Our approval of the application, evidence of insurability, and the required premium, coverage shall become effective on the first day of the Contract Month following the date We approve the application.

Article III — Payment of Benefits/Participant Provider Relationship

1. **Payment of Benefits**

   a. When benefits are payable, We may choose to pay either You or the Provider. This payment constitutes Our full responsibility to the Subscriber under this Contract.

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

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

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

2. **Participant/Provider Relationship**

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

Article IV — Benefits Provided

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

a. **Introduction**

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

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

b. **How the Medical Plan Works**

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

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

(a) The billed charges,

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

(c) Other contractually determined payment amounts,

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

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

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

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

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

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

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

c. **Medical Necessity**

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

d. **ParPlan Providers**

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

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

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

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

e. **Precertification Requirements**

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

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

(1) **Hospital Admissions**

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

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.

Your Provider may request an extension for additional inpatient days. If an admission extension is not precertified, benefits may be reduced or denied.

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

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

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

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

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

Precertification 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;
- 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.

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 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.**

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

(3) **Organ and Tissue Transplants**

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

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

f. **Copayment Amounts and Deductibles**

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

(1) **Copayment Amounts**

(a) The Copayment Amounts indicated on Your application for this Contract will be required for most Physician office visits except for services provided by an Independent Lab or radiologist requested by the Physician. If the services provided require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. For more details about how Copayment Amounts are applied, refer to the Network Benefits Managed Care Copayment Amount Chart in the beginning of this Contract. The Copayment Amount is required even if the Coinsurance Amounts have been met.

(b) A $75 Copayment Amount is required for each emergency/treatment room visit. The Copayment Amount will be waived if the Participant is admitted to the Hospital immediately following the visit.

(c) The Physician office visit Copayment Amount does not apply when services are provided by an Out-of-Network Physician or Professional Other Provider.

(2) **Deductibles**

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

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

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

g. **Coinsurance Amounts**

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

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

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

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

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

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

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

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

(e) Any Copayment Amounts under the Prescription Drug Program.

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

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

h. **Maximum Benefits**

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

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

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

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

i. **Benefits for Inpatient Hospital Expense**

If *Inpatient Hospital Expense* is incurred during each Hospital Admission in excess of the Deductible specified above, benefits will be provided at the percentage indicated on Your application for coverage under this Contract for services received in a Network Hospital or out-of-network Hospital.

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

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

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

k. **Benefits for Extended Care Expense**

When *Extended Care Expense* is precertified, We will provide benefits at: (a) 100% for Network Benefits, and (b) 75% for Out-of-Network Benefits, up to the amount of the combined benefit maximums shown below for each category of *Extended Care Expense*. The Deductible will not apply to *Extended Care Expense*.

Any Home Health Care or home Hospice Care charges for drugs (including antibiotic therapy) and laboratory services will not be *Extended Care Expense* but will be considered *Medical-Surgical Expense*.

Services and supplies for *Extended Care Expense*:

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

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

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

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

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

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

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

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

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

(e) Benefits will *not* be provided for Home Health Care for the following:
i). Food or home delivered meals;
ii). Social case work or homemaker services;
iii). Services provided primarily for Custodial Care;
iv). Transportation services;
v). Home Infusion Therapy;
vi). Durable medical equipment.

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

(a) For Home Hospice Care:

i). Part-time or intermittent nursing care by a registered nurse (R.N.)

or by a licensed vocational nurse (L.V.N.);

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

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

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

(b) For Facility Hospice Care:

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

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

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

l. **Case Management**

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

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

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

(2) The benefits are cost effective; and

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

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

m. **Special Benefit Provisions**

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

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

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

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

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

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

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

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

Calendar Year for each Participant. The Deductible will be applied.

(4) Benefits for Mammography Screening

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

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

(5) Benefits for Cosmetic, Reconstructive, or Plastic Surgery

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

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

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

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

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

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

i). Been performed; and
ii). Not been performed.

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

(6) Benefits for Certain Tests for Detection of Prostate Cancer

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

- Such Participant shall be entitled to benefits for:
  - ~ 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, and
- Benefits will be provided as described in the subsection entitled "Benefits for Medical-Surgical Expense." The Copayment Amount will be required for Network Benefit for Physician office visits. The Calendar Year Deductible will apply to Out-of-Network Benefits.

(7) Benefits for Dental Services

(a) If a Participant incurs Eligible Expenses for the dental services listed below, benefits will be the same as for

treatment of any other sickness as described in this Contract. Benefits will be provided only for:

i) Oral Surgery; or

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

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

a) For 24 months from the date of accident; or

b) To the termination date of this Contract,

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

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

(8) **Benefits for Emergency Care**

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

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

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

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

All treatment received during the first 48 hours following the onset of a medical emergency will be eligible for Network Benefits. After 48 hours, Network Benefits will be available only if You use Network Providers. If after the first 48 hours of treatment following the onset of a medical emergency, and if You can safely be transferred to the care of a Network Provider but are treated by an Out-of-Network Provider, only Out-of-Network Benefits will be available without a referral by a Network Provider authorized by BCBSTX.

Network and Out-of-Network Benefits for Eligible Expenses will be determined on the same basis as for treatment of any other sickness. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room visit as indicated on Your application for coverage under this Contract. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived.

(9) **Benefits for Preventive Care**

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

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

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

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

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

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

(10) **Benefits for Childhood Immunizations**

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

Benefits are available for:

(a) Diphtheria,
(b) Hemophilus influenza type b,
(c) Hepatitis B,
(d) Measles,
(e) Mumps,
(f) Pertussis,
(g) Polio,
(h) Rubella,
(i) Tetanus,
(j) Varicella, and
(k) Any other immunization that is required by law for the child.

Allergy injections are not considered immunizations under this benefit provision.

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

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

Please be advised You can only access the selected transplant Hospitals through Our 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.

(a) 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:

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

ii) Donated human organs or tissue are used;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

iv) Purchase of the organ or tissue.

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

(f) The total amount of benefits for organ and tissue transplants available to any one Participant under this Contract shall not exceed a $250,000 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 provided under the Prescription Drug Program and will be subject to the Calendar Year maximum benefit amount specified in Article IV, Section 2e, of this Contract.

2. **Prescription Drug Program**

a. **How it Works**

When You need a prescription filled You can elect to go to a BCBSTX Participating Pharmacy, or a Non-Participating Pharmacy.

b. **Maximum Allowable Cost (MAC)**

When Your Physician or Professional Other Provider has marked the Prescription Order, "Dispense as Written" (DAW), the pharmacist may *only* dispense the brand name drug. However, if the Physician or Professional Other Provider has not stipulated, You may still choose to buy the brand name drug instead of the Generic Substituted Drug. You will have to pay the brand Copayment Amount, plus the difference between the pharmacist's Maximum Allowable Cost for the generic drug and the brand name drug.

c. **Participating Pharmacy**

When You go to a Participating Pharmacy:

(1) Present Your Identification Card to the pharmacist along with Your Prescription Order

(2) Provide the pharmacist with the birth date and relationship of the patient

(3) Sign the insurance claim log

(4) Pay the appropriate Copayment Amount, and any Maximum Allowable Cost (MAC) pricing difference.

When You have a Prescription Order filled at Your Participating Pharmacy, You pay the Pharmacy one of the Copayment Amounts shown on Your Identification Card for each prescription or refill. Participating Pharmacies have agreed not to bill You for any covered prescription drug benefit provided to You in excess of the Copayment

Amount plus any MAC pricing difference. If the drug dispensed is a Generic Substituted Drug, You pay the generic drug Copayment Amount; otherwise You pay the brand Copayment Amount and any MAC pricing difference.

BCBSTX Participating Pharmacies will display the Blue Cross and Blue Shield of Texas emblem. If You are unsure whether a Pharmacy is a Participating Pharmacy, You may contact the Customer Service Helpline. **You must present Your Identification Card to the Pharmacy in order to receive full Plan benefits.**

d. **Non-Participating Pharmacy**

If You have a Prescription Order filled at a Pharmacy which has not entered into an agreement with BCBSTX, You must pay the Pharmacy the full amount of its bill and submit a claim form and itemized receipt to BCBSTX verifying that the prescription was filled. Benefits will be provided at 80% of the billed charge (but not more than 80% of the Average Wholesale Price, plus a dispensing fee), less the appropriate Copayment Amount and any applicable MAC pricing.

e. **Maximum Prescription Drug Benefit**

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

f. **Your Identification Card**

The Identification Card You received is the key to Your use of the Plan. It contains important information about You, Your family, and the benefits You are entitled to. Participating Pharmacies are not permitted to file claims with the Carrier unless You present the Identification Card with Your Prescription Order.

The Identification Card has important information You should be aware of. It tells Participating Pharmacies that You are entitled to prescription drug benefits under the Blue Cross and Blue Shield of Texas Prescription Drug Program.

Note: If You do not have Your Identification Card, You must pay Your Participating Pharmacy directly for Your prescription charges. You will then be reimbursed for Your payments less the appropriate Copayment Amount and any applicable MAC pricing. **Be sure to use Your Participating Pharmacy every time, even if You have not received Your Identification Card, or do not have it with You.**

Please remember that any time a change in Your family takes place it may be necessary for a new Identification Card to be issued to You. Upon receipt of the change information, We will issue a new Identification Card.

g. **Unauthorized, Fraudulent, Improper or Abusive Use of Identification Cards**

(1) The unauthorized, fraudulent, improper or abusive use of Identification Cards issued to You and Your covered family members will include, but not be limited to:

(a) Use of the Identification Card prior to Your Effective Date;

(b) Use of the Identification Card after Your date of termination of coverage under this Contract;

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

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

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

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

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

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

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

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

(a) Denial of benefits;

(b) Cancellation of coverage under this Contract **of all** Participants under Your coverage;

(c) Limitation on the use of Identification Card to one designated Participating Pharmacy of Your choice;

(d) Recoupment from You or any of Your covered family members of any benefit payments made;

(e) Pre-approval of drug purchases for all Participants covered under Your coverage;

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

h. **What it Covers**

The Prescription Drug Program will provide benefits for those Covered Drugs prescribed for Your use by Your Provider which require a valid Prescription Order before they can be sold to You, and which are required by law to have a label stating "Caution—Federal Law Prohibits Dispensing Without a Prescription." These drugs are commonly called "Legend Drugs."

(1) ***Generic Substituted Drugs***

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

(2) ***Amount of Your Payment***

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

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

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

i. **Limitations on Quantities Dispensed**

This Contract will normally pay for no more than a 30-calendar-day supply of a Covered Drug on each occasion when You have a prescription filled or refilled. However, Prescription Orders for certain chronic conditions may be dispensed in amounts not to exceed 100 or 200 individual doses or a 90-calendar-day supply at a time as indicated below. If the dosage quantities allowed below for a particular Participant result in an amount to be dispensed that is less than a 30-calendar-day supply, a 30-calendar-day supply will be permitted.

(1) 30-calendar-day supply quantities:

Oral contraceptive medications which are Legend Drugs

(2) 100 individual dose quantities:

Anticoagulants
Antifungal Agents
Covered Prenatal Vitamins
Urinary and Intestinal Anti-infectives

(3) 200 individual dose quantities:

Antiarthritic Drugs
Anticholinergic and Parasympatholytic Agents
Anticonvulsants
Antidiabetics
Antihistamines
Cardiac Drugs
Diuretics
Hormones
Hypotensive Agents
Thyroid Preparations

Injectable drugs for self-administration are also covered under this Contract. You will be limited to no more than four 10-cc vials of insulin on each occasion You have a prescription filled or refilled.

The quantity of disposable syringes and needles needed for self-administered injections will be limited, on each occasion dispensed, to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles per prescription.

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

Article V — Limitations and Exclusions

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

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

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

   c. 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 not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or any laws, regulations or established procedures of any county or municipality, except as provided in Article VIII, Section 8. This Subsection 1c 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.

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

   e. 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).

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

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

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

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

   j. 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.

   k. 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 f, of this Contract.

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

m. Any services or supplies for Custodial Care.

n. 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) preventive care, (3) childhood immunizations, and (4) certain tests for the detection of prostate cancer, except as provided for in the Special Benefit Provisions section in Article IV of this Contract.

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

p. 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.

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

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

s. Any services or supplies provided for:

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

(2) Orthoptics or visual training; or

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

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

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

u. Any services or supplies provided by a Licensed Hearing Aid Fitter and Dispenser.

v. 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; any services or supplies provided by a Licensed Master Social Worker-Advanced Clinical Practitioner, a Licensed Professional Counselor, or a Marriage and Family Therapist.

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

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

y. 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.

z. 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.

aa. 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.

bb. Any services or supplies provided primarily for:

(1) Environmental Sensitivity; or
(2) Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
(3) Inpatient allergy testing or treatment.

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

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

(1) Sterilization reversal (male or female);

(2) Transsexual surgery;

(3) Sexual dysfunction;

(4) In vitro fertilization services; and

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

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

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

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

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

(a) Clinical evidence of mycosis of the toenail;

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

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

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

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

ff. 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.

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

hh. Any Speech and Hearing Services except for: (1) *Extended Care Expense*; and (2) preventive care as provided in Article IV, Section 1, of this Contract.

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

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

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

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

jj. Any services or supplies for reduction mammoplasty.

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

ll. Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase, other than injectable drugs administered by or under the direct supervision of a Physician or Professional Other Provider, except as provided under the Prescription Drug Program.

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

nn. 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.

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

pp. Any services or supplies not specifically defined as an Eligible Expense under Section 1 of this Contract.

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

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

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

c. Administration or injection of any drugs.

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

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

f. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which

benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that the exclusions of this Section (f) shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

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

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

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

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

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

l. Covered Drugs dispensed in quantities in excess of the amounts stipulated in **Limitations on Quantities Dispensed** or refills of any prescriptions in excess of the number of refills specified by the Physician or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.

m. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which FDA approval is given.

n. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting.

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

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

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

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

s. Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.

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

Article VI — Termination of Coverage

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

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

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

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

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

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

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

g. In the event this Contract is terminated in accordance with the provisions of Subsection 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:

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

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

(3) A period not less than 90 days.

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

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

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

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

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

a. At the end of the Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section 15, of this Contract, provided that:

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

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

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

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

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

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

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

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

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

   In the case of a change in marital status, the new Contract will have the same Effective Date as the Contract under which coverage was afforded prior to the loss of coverage. The rights provided under this Section 4 shall terminate if no application is received by Us within the 30-day period.

Article VII — Standard Provisions

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

2. **Contract; Amendments:**

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

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

3. **Grace Period:** A grace period of: (1) ten days for monthly, or (2) 30 days for quarterly payment of premiums shall be allowed from the due date of each premium payment, during which grace period this Contract will continue in force, subject to its termination in accordance with the provisions hereof.

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

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

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

7. **Physical Examinations and Autopsy:** We, at Our own expense, shall have the right and opportunity to examine the person of the Participant for whom claim is made, when and so often as We may reasonably require during

the pendency of a claim hereunder and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.

8. **Proof of Loss:**

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

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

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

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

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

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

Article VIII — General Provisions

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

2. **Disclosure Authorization:**

   a. In consideration of Our having waived physical examination in connection with the application, You, on behalf of Yourself and Your Dependents, shall be deemed to have authorized any attending Physician, Other Provider or Hospital to furnish Us all information and records or copies of records

relating to the diagnosis, treatment, or care of any Participant included under this Contract; and such Participants shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

b. As a condition to the continued coverage of a child as a disabled Dependent beyond the age of 23, We shall have the right to require periodic certification of the child's physical or mental condition and dependency, but not more frequently than annually after the two-year period following the child's attainment of age 23.

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

4. **Non-Agency:** You understand that this Contract constitutes a contract solely between You and Us. We are an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association). The license from the Association permits Us to use the Blue Cross and Blue Shield Service Marks in the State of Texas. We are not contracting as the agent of the Association. You also understand that You have not entered into this Contract based upon representations by any person other than Us. No person, entity, or organization other than Us shall be held accountable or liable to You for any of Our obligations created under this Contract. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of this Contract.

5. **Premiums:**

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

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

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

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

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

(2) **Change of Residence:** If You change Your place of residence and such change results in a change in premium, the premium applicable to this Contract shall automatically change to the rate applicable to the new place of residence effective on the first day of the Contract Month following the date of change in residence; provided that if such change is to a lower premium rate and You fail to notify Us in writing of such change prior to the date of change, Your right to refund of overpayment shall be limited to the overpayment for the six months immediately preceding the date of notification to Us.

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

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

reserve the right to offset subsequent benefit payments otherwise payable by the amount of any such overpayment.

7. **Review of Claim Determinations:**

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

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

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

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

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

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

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

8. **State Government Programs:**

   a. Benefits for services or supplies under this Contract shall not be excluded solely because benefits are paid or payable for such services or supplies under a state plan for medical assistance (Medicaid) made pursuant to 42 U.S.C., Section 1346 et seq., as amended. Any benefits payable under such state plan for medical assistance shall be payable to the Texas Department of Human Services to the extent required by Article 21.4910 of the *Texas Insurance Code*.

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

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

      (2) The parent who is covered by this Contract has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and

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

9. **Subrogation:** If the Carrier pays or provides benefits for the Subscriber or the Subscriber's Dependents under this Contract. the Carrier is subrogated to all rights of recovery which the Subscriber or the Subscriber's Dependent 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 Subscriber's 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 (the Subscriber or the Subscriber's Dependent) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

Right of Reimbursement

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

If the Subscriber or the Subscriber's Dependent recovers money from any person, organization or insurer for an injury or condition for which the Carrier paid benefits under this Contract, the Subscriber or the Subscriber's Dependent agree to reimburse the Carrier from the recovered money for the amount of benefits paid or provided by the Carrier. That means the Subscriber or the Subscriber's Dependent will pay to the Carrier the amount of money recovered by the Subscriber 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

The Subscriber or the Subscriber's Dependent agree to promptly furnish to the Carrier all information which the Subscriber have concerning the Subscriber's 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. The Subscriber, the Subscriber's Dependent or the Subscriber's 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. The Subscriber or the Subscriber's Dependent further agrees not to allow the reimbursement and subrogation rights of the Carrier to be limited or harmed by any acts or failure to act on the Subscriber's part.

Notices

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 LIMITATIONS 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 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's 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 benefits 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

IMPORTANT TO YOUR COVERAGE

To pay less out-of-pocket expenses and to receive the higher level of benefits for your health care costs, it is to your advantage to use Network Providers. If you use Network Providers, you will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much you would pay if you use a Network Provider and how much you would pay if you use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same:

EXAMPLE ONLY

	In-Network 85% of eligible charges $500 Deductible	**Out-of-Network** 75% of eligible charges $1,000 Deductible
Amount Billed	$20,000	$20,000
Allowable Amount	$5,000	$5,000
Deductible Amount	$500	$1,000
Plan's Coinsurance Amount	$3,825	$3,000
Your Coinsurance Amount	$675	$1,000
Non-Contracting Provider's additional charge to you	None	$15,000[1]
YOUR TOTAL PAYMENT	**$1,175** **to a Network Provider**	**$17,000** **to a Non-contracting Out-of-Network Provider**

Even when you consult a Network Provider, ask questions about any of the Providers rendering care to you. For example, if you are scheduled for surgery ensure that your Network surgeon will be using a Network facility for your procedure and a Network Provider for your anesthesia services.

[1] If you choose to receive services from an Out-of-Network Provider, inquire if he participates in a contractual arrangement with BCBCTX. Providers who do not contract with BCBSTX or any other Blue Cross and Blue Shield plan will bill the patient for expenses over the Allowable Amount. Please refer to the section entitled *PARPLAN* in the Contract.

NOTICE OF MANDATED BENEFITS

This notice is to advise you of certain coverage and/or benefits provided in your health plan insured by Blue Cross and Blue Shield of Texas. This notice is required by legislation to be provided to you. *If you have questions regarding this notice, call Blue Cross and Blue Shield of Texas at 1-800-521-2227 or write us at P.O. Box 655730, Dallas, Texas 75265.*

Mastectomy or Lymph Node Dissection

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

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

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

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

Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician. Deductibles, coinsurance and copayment amounts will be the same as those applied to other similarly covered *Inpatient Hospital Expense* or *Medical-Surgical Expense*, as shown on the Schedule of Coverage.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Prostate Cancer Detection Examinations

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

- A physical examination for the detection of prostate cancer; and
- A prostate-specific antigen test for each covered male who is:
  - At least 50 years of age; or
  - At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Cont'd

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Inpatient Stay Following Birth of a Child

For each person covered for maternity/ childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

a. 48 hours following an uncomplicated vaginal delivery; and

b. 96 hours following an uncomplicated delivery by Cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to:

a. give birth in a hospital or other health care facility; or

b. remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

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

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

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or

(b) a colonoscopy performed every ten years.

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NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your Contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Services Corporation.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred in conducting an annually medically required diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or screening using liquid-based cytology methods as approved by the United States Food and Drug Administration for the detection of human Papillomavirus.

If any person covered by this Plan has a question concerning the above, please call Blue Cross and Blue Shield of Texas at: 1-888-697-0683, or write to us at: P. O. Box 2035, Aurora, Illinois 60507-2035.

NOTICE TO BLUE CROSS AND BLUE SHIELD OF TEXAS CONTRACTHOLDER

BlueCard

Like all Blue Cross and Blue Shield Licensees, the Plan participates in a program called "BlueCard." Whenever Participants access health care services outside the Plan's service area, the claims for those services may be processed through BlueCard and presented to the Plan for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Participants receive covered services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), the Plan will remain responsible to the Contractholder for fulfilling the Plan's contract obligations.

However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers, handling all interaction with its participating Providers. The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

The calculation of the Participant's liability on claims for covered services incurred outside the Plan's service area and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price the Plan pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by the Plan on a claim for health care services processed through BlueCard may represent:

(i) The actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"), or

(ii) An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or

(iii) An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Participant and the Contractholder from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or an Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over– or underestimation of past prices. However, the amount paid by the Participant is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating the Participant's liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate the Participant's liability for any covered services consistent with the applicable state statute in effect at the time the Participant received those covered services.

Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

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 Randolph, Chicago, Illinois at 12:30 p.m. on the last Tuesday in October.

Amendments

An Amendment

Effective January 1, 2000

To be attached to and made a part of your Blue Cross and Blue Shield PPO Select Advantage Plan Insurance Contract.

Your Contract is amended as follows:

1. The **Definitions** section 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.**

2. The **Benefits Provided** section 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.

3. The **Limitations and Exclusions** section is amended by:

a. Deleting the wording of Subsection n in its entirety and substituting the following:

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

a. Mammography screening,
b. Preventive Care,
c. Childhood immunizations,
d. Certain tests for the detection of prostate cancer; or
e. Screening tests for hearing impairment.

b. Deleting the wording of Subsection u in its entirety and substituting the following:

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

c. Deleting the wording of Subsection hh in its entirety and substituting the following:

hh. Any Speech and Hearing Services. This exclusion does not apply to the following as described in Article IV of this Contract.

a. *Extended Care Expense*,
b. Preventive Care; and
c. Screening tests for hearing impairment

President

An Amendment

Effective January 1, 2002

To be attached to and made a part of your Blue Cross and Blue Shield of Texas* PPO Select® Advantage Plan Insurance Contract.

Your Contract is amended as follows:

1. The **Network Benefits, Copayment Amount Chart** is deleted in its entirety.

2. Article I of this Contract is amended by deleting the wording of Section 2 in its entirety and substituting 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 and 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*** – The Allowable Amount will be the amount BCBSTX would have considered for payment for the same procedure, service, or supply at an equivalent contracting Hospital or Facility Other Provider, using Texas regional or state fee schedules or rate and payment methodologies. For Hospitals or Facility Other Providers where fee schedules or rate payments are not appropriate, the Allowable Amount will be the lesser of billed charge or a per diem established by BCBSTX.

   - ***For procedures, services or supplies provided in Texas by Physicians and Professional Other Providers not contracting with BCBSTX*** – The Allowable Amount will 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.

     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.

   - ***For procedures, services or supplies performed outside of 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 Texas regional or state allowable amounts applicable to procedures, services or supplies of Physicians or Professional Other Providers with similar skills and experience.

   - ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount *plus* one-half of the Allowable Amount *for each* of the other 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 established by BCBSTX and updated on a periodic basis.

- ***For procedures, services or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare's limiting charge.

3. Article I of this Contract is amended by deleting the wording of Section 15 in its entirety and substituting the following:

   15. **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.

4. Article I, of this Contract is amended by deleting the wording of Section 38 in its entirety and substituting the following:

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

5. Article I, Section 44 of this Contract is amended by deleting the wording of subsection l in its entirety and substituting the following:

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

6. Article I, Section 44 of this Contract is amended by adding the following new subsections:

   Outpatient Contraceptive Services and prescription contraceptive devices. However, coverage for prescription oral contraception medications is provided under the Prescription Drug Program.

   Telehealth Service and Telemedicine Medical Service.

7. Article I, Section 52, of this Contract is amended by adding the following Professional Other Provider:

   Nurse First Assistant

8. Article I of this Contract is amended by adding the following new definitions:

Compound Drugs means those drugs, which meet the following requirements:

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

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

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.

8. Article III, Section 1, of this Contract is amended by deleting the wording of Subsections a and b in their entirety and substituting the following:

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

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

9. Article IV, Section 1e(1) of this Contract is amended by deleting the wording of the second sentence in the first paragraph in its entirety and substituting the following:

In an emergency, precertification should take place within two working days after the admission or as soon as reasonable possible.

10. Article IV, Section 1e(2) of this Contract is amended by deleting the wording of the second sentence of the fourth paragraph in its entirety and substituting the following:

A letter will be sent to You and the agency or facility confirming precertification or denying benefits.

11. Article IV, Section 1f of this Contract is amended by deleting the wording of Subsections (1)(a) and (1)(b) in their entirety and substituting the following:

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

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

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

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

12. Article IV, Section 1, of this Contract is amended by deleting the wording of Subsection (8) in its entirety and substituting the following:

(8) **Benefits for Emergency Care**

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

(1) Any medical screening examination or other evaluation required by state or federal law to be provided in the emergency department of a Hospital which is necessary to determine whether an emergency medical condition exists;
(2) Necessary Emergency Care services including the treatment and stabilization of an emergency medical condition; and
(3) Services originating in a Hospital emergency department following treatment or stabilization of an emergency medical condition.

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

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

(c) A $75 Copayment Amount will be required for each outpatient Hospital emergency room visit as indicated on Your application for coverage under this Contract. Eligible Expenses for other covered charges provided at the time of the emergency/treatment visit (e.g. facility and Physician charges and lab or X-ray) will be subject to the Deductible and Coinsurance Amounts. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived.

13. Article IV, Section 1m, of this Contract is amended by deleting Subsection (11) in its entirety and substituting the following:

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

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

i) The transplant procedure is not Experimental/Investigational in nature;
ii) Donated human organs or tissue are used;
iii) The recipient is a Participant under this Contract. Benefits are also available to a live donor to the extent that benefits remain under the recipient's contract after benefits for the recipient's expenses have been provided;
iv) The transplant procedure is precertified as provided in Section 1, Subsection e(3), of this Article IV;
v) The Participant meets all of the criteria established by Us in Our written medical policy guidelines; and
vi) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

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

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

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

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

i) For the evaluation of organs or tissues including, but not limited to, the determination of tissue matches;
ii) For the removal of organs or tissues from deceased donors; and
iii) For the transportation and storage of donated organs or tissues.

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

i) Living and/or travel expenses of the live donor or recipient;
ii) Donor search and acceptability testing of potential living donors;
iii) Expenses related to maintenance of life for purposes of organ or tissue donation; and
iv) Purchase of the organ or tissue.

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

(f) The total amount of benefits for organ and tissue transplants available to any one Participant under this Contract shall not exceed a $250,000 maximum. This maximum shall include benefits provided for prescription drugs used while in the Hospital. Benefits for drugs used on an outpatient basis will be provided under the Prescription Drug Program and will be subject to the Calendar Year maximum benefit amount specified in Article IV, Section 2e, of this Contract.

14. Article IV, Section m, of this Contract is amended by adding the following new Subsections:

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an acquired brain injury:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, neuro-physiological, neuro-psychological, and psychophysiological testing or treatment;
- Neurofeedback therapy;
- Remediation;
- Post-acute transition services; and
- Community reintegration services.

Benefits for Certain Tests for Detection of Colorectal Cancer

If a Participant 50 years of age or older and who is at normal risk for developing colon rectal cancer incurs *Medical-Surgical Expense* for a diagnostic medically recognized screening examination for the detection of colorectal cancer, benefits will be determined as described under Preventive Care, except that if the maximum benefit amount has been reached under that provision:

- Such Participant shall receive benefits for a:
  - Fecal occult blood test performed annually and flexible sigmoidoscopy performed every five years; or
  - Colonoscopy performed every ten years, and
- Benefits will be provided as described in the subsection entitled **Benefits for Medical-Surgical Expense.** The Copayment Amount will be required for Network Benefits for Physician office visits. The Calendar Year Deductible will apply to Out-of-Network Benefits.

15. Article IV, Section 2 of this Contract, is amended by deleting the wording of Subsection i in its entirety and substituting the following:

i. **Limitations on Quantities Dispensed**

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

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

16. Article V, Section 1, of this Contract is amended by deleting the wording of Section n, as previously amended, in its entirety and substituting the following:

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

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

17. Article V, Section 1, of this Contract is amended by deleting the wording of subsection t in its entirety and substituting the following:

    t. Any services or supplies for mental or nervous disorders. This exclusion does not apply to the following except as may be provided in this Contract for Organic Brain Disease as defined in Article I, and acquired brain injury as described Article IV, in this Contract, as amended.

18. Article V, Section 1, of this Contract is amended by deleting the wording of subsection v in its entirety and substituting the following:

    v. Except as specifically provided in this Contract, any Medical Social Services; any outpatient family counseling and/or therapy; bereavement counseling; vocational counseling, or any services or supplies provided by a Licensed Master Social Worker-Advanced Clinical Practitioner, Licensed Professional Counselor, or a Marriage and Family Therapist.

19. Article V, Section 1, of this Contract is amended by deleting the wording of subsection ff in its entirety and substituting the following:

    ff. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations or any Retin-A or pharmacologically similar topical drugs.

20. Article V, Section 1, of this Contract is amended by deleting the wording of subsection kk in its entirety and substituting the following:

    kk. Any smoking cessation products requiring a Prescription Order.

21. Article V, Section 1, of this Contract is amended by deleting the wording of subsection nn in its entirety and substituting the following:

    nn. Orthodontic or other dental appliances; splints or bandages provided by a Physician in a non-hospital setting or purchased "over-the-counter" for support of strains and sprains; orthopedic shoes, which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts, **except** for podiatric appliances when provided in conjunction with treatment of diabetes.

22. Article V of this Contract is amended by deleting the wording of Sections 2a and 2b in their entirety and substituting the following:

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

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

23. Article V, Section 2, of this Contract is amended by deleting the wording of subsection i in its entirety and substituting the following:

    i. Contraceptive devices, non-prescriptive contraceptive materials, (**except** oral contraceptive medications and contraceptive materials which are Legend Drugs; infertility medications and fertility medications. However, coverage for contraceptive devices is provided under the Medical portion of this Contract.

24. Article V, Section 2 of this Contract is amended by deleting the wording of subsection j in its entirety and substituting the following:

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

25. Article V, Section 2, of this Contract is amended by deleting the wording of subsection m in its entirety and substituting the following:

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

26. Article V, Section 2, of this Contract is amended by deleting the wording of subsection t in its entirety and substituting the following:

    t. Any smoking cessation products requiring a Prescription Order.

27. Article VI of this Contract is amended by deleting the wording of Section 2a(2) in its entirety and substituting the following:

    (2) Coverage for any unmarried child who is medically certified as Disabled and dependent upon you shall not terminate upon reaching age 25 if the child continues to be both (a) disabled and (b) dependent upon You for more than one-half of his support as defined by the *Internal Revenue Code* of the United States. ***Disabled*** mean any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under this Contract and before the child attains age 25. You must submit proof of the disability and dependency to Us within 31 days following the child's attainment of age 25. As a condition to the continued coverage of a child as a disabled Dependent beyond are 25. We may require periodic or mental condition but not more frequently than annually after the two-year period following the child's attainment of age 25.

28. Article VI of this Contract is amended by deleting the wording of Section 4 in its entirety and substituting the following:

    4. Notwithstanding the provision of Section 2, above, within 30 days of a divorce, marriage of a child, or attaining age 25, the former Dependent losing coverage may elect to apply for coverage in his own name.

Upon timely application, We will allow coverage under the name of the applicant without evidence of insurability at the then prevailing premium rate for persons of the same age, sex and geographical location. In the case of a change in marital status, the new Contract will have the same Effective Date as the Contract under which coverage was afforded prior to the loss of coverage. The rights provided under this Section 4 shall terminate if We do not receive the application within the 30-day period.

29. Article VII of this Contract is amended by deleted Section 3 in its entirety and substituting the following:

Grace Period: A grace period if ten days for monthly, or (2) 31 days for quarterly payment of premiums shall be allowed from the due date of each premium payment, during which the grace period this Contract will continue in force, subject to its termination in accordance with the provisions hereof.

30. Article VII of this Contract is amended by deleting the wording of Section 2b 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.

31. The Notices section is amended by deleting "The Women's Health and Cancer Rights of 1998" in its entirety and substituting the attached.

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

President

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

An Amendment

Effective Date January 1, 2004

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

1. Article I, Section 52, of this Contract is amended by deleting the term "Licensed Master Advanced-Clinical Social Worker" and substituting "Licensed Clinical Social Worker."

2. Article I of this Contract is amended by adding the following new definition:

   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.

3. Article IV of this Contract is amended by adding the following new benefit provision "***Benefits for Acquired Brain Injury***".

   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.

4. Article IV, of this Contract is amended by adding the following new benefit provision:

Certain Therapies for Children with Development Delays
Medical-Surgical Expense benefits are provided for a Dependent child under three years of age with *developmental delays* for the necessary rehabilitative and habilitative therapies in accordance with an *individualized family service plan* issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas *Human Resources Code.* Such therapies include:

- Occupational therapy evaluation and services;
- Physical therapy evaluations and services;
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations.

The *individualized family service plan* must be submitted to Us prior to the commencement of services, and when the *individualized family service plan* is altered.

Developmental delays means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

Individualized family service plan means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention.

After the age of three, when services under the *individualized family service plan* are completed, Eligible Expenses, as otherwise coverage under this Contract, will be available. All contractual provision of this Contract will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

2. Article V, Section I, of this Contract is amended by deleting the wording of subsections l, n, v and hh in their entirety and substituting the following:

l. 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***

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

(1). ***Mammography Screening;***

(2) ***Preventive Care*** up to the Calendar Year benefit maximum;

(3) ***Childhood Immunizations;***

(4) ***Certain Tests for the Detection of Prostate Cancer,***

(5) ***Newborn Screening Tests for Hearing Impairment;***

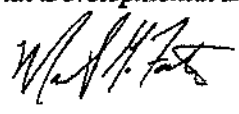
(6) ***Certain Tests for the Detection of Colorectal Cancer;*** and

(7) ***Certain Therapies for Children with Developmental Delays.***

w. Except as specifically included as an Eligible Expense, any Medical Social Services; any outpatient family counseling and/or therapy bereavement counseling, vocational counseling, Marriage and Family Therapy and/or counseling; any services provided by a Licensed Clinical Social Worker, a Licensed Professional Counselor, or a Marriage and Family Therapist.

hh. Any Speech and Hearing Services. This exclusion does not apply to the following except as provided in the Special Benefit Provisions section of Article IV, Section 1, of this Contract:

(1) *Extended Care Expense*;
(2) ***Preventive Care*** up to the Calendar Year benefit maximum;
(3) ***Newborn Screening Tests for Hearing Impairment***; and
(4) ***Certain Therapies for Children with Developmental Delay.***



President of Blue Cross and Blue Shield of Texas

An Amendment

Effective Date January 1, 2006

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

1. Article IV of this Contract is amended by deleting the section entitled "***Benefits for Preventive Care***" in its entirety and substituting the following:

Benefits for Preventive Care

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

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

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

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

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

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

Benefits for routine mammography screening, colorectal cancer screening, prostate cancer screening, and HPV/cervical cancer screening are not available under this preventive care benefit.

2. Article IV of this Contract is amended by adding the following new benefit provision:

Benefits for Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer

If a female Participant 18 years of age or older incurs *Medical–Surgical Expense* for an annual medically recognized diagnostic examination for the early detection of cervical cancer, benefits provided under this Contract shall include:

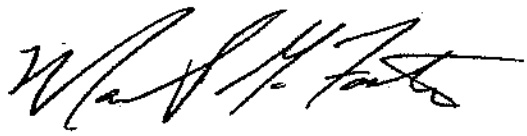
- A conventional Pap smear screening or a screening using liquid–based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of human Papillomavirus.
- Such screening test must be performed in accordance with the guidelines adopted by:

  (a) The American College of obstetricians and Gynecologists; or
  (b) Another similar national organization of medical professionals.

3. Article V, Section 1, of this Contract is amended by deleting the wording of subsection n in its entirety and substituting the following:

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

      1. ***Mammography Screening;***
      2. ***Preventive Care*** up to the Calendar Year benefit maximum;
      3. ***Childhood Immunizations;***
      4. ***Certain Tests for the Detection of Prostate Cancer;***
      5. ***Newborn Screening Tests for Hearing Impairment;***
      6. ***Certain Tests for the Detection Colorectal Cancer Screening;***
      7. ***Certain Therapies for Children with Developmental Delays;*** and
      8. ***Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer.***



President of Blue Cross and Blue Shield of Texas

An Amendment

Effective January 1, 2006 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: 

President

Date: _____