

**Notice:** This Contract is subject to: (1) maximum lifetime benefits; (2) premium increase as specified in Article VIII; and (3) termination upon the Subscriber's attainment of age 65.

**Select<sup>TM</sup>**  
**2000**

**Select 2000 Plan**  
**For Individuals and Families**

An Individual Contract  
Providing Comprehensive Major Medical Coverage

Issued By  
**Blue Cross and Blue Shield of Texas, Inc.**  
Richardson, Dallas County, Texas

to

The Subscriber Named on the Enclosed Identification Card

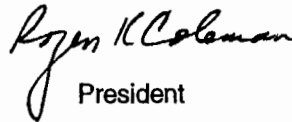
**Blue Cross and Blue Shield of Texas, Inc.**  
(Herein called the Carrier)

Home Office: Richardson, Dallas County, Texas

Has issued this individual Select 2000™ Plan Contract to the Subscriber named on the identification card enclosed with the Contract.

The **Effective Date** of this Contract is the Effective Date stated on the identification card.

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

  
President

# Table of Contents

	Page No.		Page No.
<b>Article I — Definitions</b>		<b>Article III — Payment of Benefits; Participant/Provider Relationship</b>	
Calendar Year . . . . .	1	Payment of Benefits . . . . .	7
Chemical Dependency . . . . .	1	Participant/Provider Relationship . . . . .	8
Clinical Ecology . . . . .	1	<b>Article IV — Benefits Provided</b>	
Coinsurance Amount . . . . .	1	Precertification . . . . .	8
Complications of Pregnancy . . . . .	1	Deductible . . . . .	8
Contract Month . . . . .	1	Benefits for Inpatient Hospital Expense . . . . .	9
Contracting Facility . . . . .	1	Benefits for Medical-Surgical Expense	
Cosmetic, Reconstructive, or Plastic Surgery . . . . .	1	Benefit Determination . . . . .	9
Covered Oral Surgery . . . . .	1	Exception . . . . .	9
Custodial Care . . . . .	1	Benefits for Extended Care Expense	
Dependent . . . . .	1	Skilled Nursing Facility . . . . .	9
Dietary and Nutritional Services . . . . .	2	Home Health Agency Care . . . . .	9
Eligible Expenses . . . . .	2	Hospice Care . . . . .	10
Emergency Care . . . . .	2	Benefits for Treatment of Complications	
Environmental Sensitivity . . . . .	2	of Pregnancy/Maternity Care . . . . .	10
Experimental/Investigational . . . . .	2	Benefits for Mammography Screening . . . . .	10
Extended Care Expense . . . . .	2	Benefits for Organ Transplants . . . . .	10
Home Health Agency . . . . .	3	Benefits for Well-Child Care . . . . .	10
Home Health Care . . . . .	3	Coinsurance Stop-Loss . . . . .	11
Home Infusion Therapy . . . . .	3	Large Case Management . . . . .	11
Home Infusion Therapy Provider . . . . .	3	Maximum Lifetime Benefits . . . . .	11
Hospice . . . . .	3	<b>Article V — Limitations and Exclusions</b>	11
Hospice Care . . . . .	3	<b>Article VI — Termination of Coverage</b>	13
Hospital . . . . .	3	<b>Article VII — Standard Provisions</b>	
Hospital Admission . . . . .	3	Claim Forms . . . . .	14
Inpatient Hospital Expense . . . . .	3	Contract; Amendments . . . . .	14
Marriage and Family Therapy . . . . .	4	Grace Period . . . . .	14
Maternity Care . . . . .	4	Legal Actions . . . . .	14
Medical Social Services . . . . .	4	Misstatement of Age . . . . .	14
Medical-Surgical Expense . . . . .	4	Notice of Claim . . . . .	14
Medically Necessary or Medical Necessity . . . . .	5	Physical Examinations and Autopsy . . . . .	15
Member Hospital . . . . .	5	Proof of Loss . . . . .	15
Mental Health Care . . . . .	5	Reinstatement . . . . .	15
Noncontracting Facility . . . . .	5	Time Limit on Certain Defenses . . . . .	15
Nonmember Hospital . . . . .	5	<b>Article VIII — General Provisions</b>	
Other Provider . . . . .	6	Applicable Law . . . . .	15
Participant . . . . .	6	Disclaimer . . . . .	15
Physical Medicine Services . . . . .	6	Disclosure Authorization . . . . .	15
Physician . . . . .	6	Gender . . . . .	16
Preexisting Condition . . . . .	6	Premiums . . . . .	16
Proof of Loss . . . . .	6	Refund of Benefit Payments . . . . .	16
Prosthetic Appliances . . . . .	6	Review of Claim Determinations . . . . .	16
Provider . . . . .	6	State Government Programs . . . . .	17
Reasonable Charge . . . . .	6	Subrogation . . . . .	17
Renal Dialysis Center . . . . .	7		
Second Surgical Opinion Services . . . . .	7		
Skilled Nursing Facility . . . . .	7		
Speech and Hearing Services . . . . .	7		
Subscriber . . . . .	7		
Therapeutic Center . . . . .	7		
<b>Article II — Effective Date of Dependent Coverage</b>	7		

## Article I — Definitions

As used herein:

- A. **Calendar Year** means the period commencing on a January 1 and ending on the next succeeding December 31, inclusive.
- B. **Clinical Ecology** means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:
1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells); or
  2. Urine auto injection (injecting one's own urine into the tissue of the body); or
  3. Skin irritation by Rinkel method; or
  4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
  5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).
- C. **Chemical Dependency** means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.
- D. **Coinsurance Amount** means the dollar amount of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under this Contract. Such Eligible Expenses do not include:
1. The penalty amount if precertification is not obtained, or the deductible;
  2. Services, supplies, or charges limited or excluded by this Contract; or
  3. Expenses not covered because a benefit maximum has been paid.
- E. **Complications of Pregnancy** means:
1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as 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. Services and supplies provided at termination of pregnancy shall not be considered treatment of Complications of Pregnancy as defined in this Subsection 1.
  2. 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.
- F. **Contract Month** means each succeeding monthly period, beginning on the Effective Date.
- G. **Contracting Facility** means a Hospital, a Facility Other Provider, or any other facility or institution with which the Carrier has executed a written contract pursuant to Article 20.11, *Texas Insurance Code*, for the provision of care, services, or supplies furnished within the scope of its license for benefits available under this Contract. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in this Contract shall be deemed a Noncontracting Facility regardless of the existence of a written contract with another Blue Cross Plan.
- H. **Cosmetic, Reconstructive, or Plastic Surgery** means that surgery which:
1. Can be expected or is intended to improve the physical appearance of a Participant; or
  2. Is performed for psychological purposes; or
  3. Restores form but does not correct or materially restore a bodily function.
- I. **Covered Oral Surgery** means maxillofacial surgical procedures limited to:
1. Excision of nondental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
  2. Incision and drainage of facial abscess;
  3. Surgical procedures involving salivary glands and ducts and nondental related procedures of the accessory sinuses; and
  4. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded in Article V, Section P, of this Contract.
- J. **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.
- K. **Dependent** means:
1. A Subscriber's spouse; or

2. Any unmarried child who is under 23 years of age; or
3. Any unmarried disabled child, provided that in the case of a disabled child who has reached age 23, such child is dependent upon the Subscriber for more than one-half of his support as defined by the Internal Revenue Code of the United States.

"Child" means:

1. The natural child of the Subscriber; or
2. A legally adopted child of the Subscriber (including a child living with the adopting parents during the period of probation); or
3. A stepchild of the Subscriber whose primary residence is the Subscriber's household; or
4. A child of the Subscriber's child who is dependent upon the Subscriber for more than one-half of his support as defined by the Internal Revenue Code of the United States; or
5. A child:
  - a. Whose primary residence is your household; and
  - b. To whom you are legal guardian or related by blood or marriage; and
  - c. Who is 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 which prevents the child from engaging in self-sustaining employment; provided that the disability commences prior to such child's attainment of age 23 and that satisfactory proof of such disability and dependency is submitted by the Subscriber to the Carrier within 31 days following the child's attainment of age 23. As a condition to the continued coverage of a child as a disabled Dependent beyond age 23, the Carrier shall have the right to 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.

- L. **Dietary and Nutritional Services** means the education, counseling, or training of a Participant (including printed material) regarding: (1) diet; (2) regulation or management of diet; or (3) the assessment or management of nutrition.
- M. **Eligible Expenses** means either *Inpatient Hospital Expense*, *Medical-Surgical Expense*, or *Extended Care Expense*, all as specified in this Contract.
- N. **Emergency Care** means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the Parti-

part's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ. Benefits for Emergency Care will be determined on the same basis as for any other sickness.

- O. **Environmental Sensitivity** means the inpatient or outpatient treatment of allergic symptoms by:
  1. Controlled environment; or
  2. Sanitizing the surroundings, removal of toxic materials; or
  3. Use of special nonorganic, nonrepetitive diet techniques.

- P. **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: (1) have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated; (2) are appropriate for the Hospital or Facility Other Provider in which they were performed; and (3) the Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of the Carrier 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 its determination.

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

- Q. **Extended Care Expense** means the services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in Article IV, Section E.
- R. **Home Health Agency** means a business that provides Home Health Care and is licensed by the Department of Health under Article 4447u, *Vernon's Texas Civil*

**Statutes.** 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.

**S. 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.

**T. 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:

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

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

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

**V. Hospice** means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which: (1) is licensed in accordance with state law (where the state law provides for such licensing); and (2) is certified by Medicare as a supplier of Hospice Care.

**W. 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.

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

1. Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by

or under the supervision of Physicians for compensation from its patients;

3. Has organized departments of medicine and major surgery and maintains clinical records on all patients;
4. Provides 24-hour nursing services by or under the supervision of Registered Nurses;
5. Has in effect a Hospital Utilization Review Plan; and
6. Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of alcohol abuse or drug abuse, hospice, place for the provision of rehabilitative care, or a place for the treatment of pulmonary tuberculosis.

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

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

**Z. 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: (1) furnished at the direction or prescription of a Physician or Professional Other Provider; (2) provided by a Member or Nonmember Hospital (for Nonmember Hospitals such charges must be reasonable as determined by the Carrier); and (3) 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:

1. Room accommodation charges, provided that if the Participant is confined in a private room, the excess of the room accommodation charge over the Hospital's average semiprivate room accommodation charge will not be considered hereunder for any purpose.

2. All other care in the nature of usual Hospital services which are Medically Necessary and consistent with the condition of the Participant. Personal items are not included as *Inpatient Hospital Expense*.

AA. **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.

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

AC. **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:

1. Assessment of the social and emotional factors related to the Participant's sickness, need for care, response to treatment and adjustment to care; and
2. Assessment of the relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

AD. **Medical-Surgical Expense** means the Reasonable Charge incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are: (1) furnished by or at the direction or prescription of a Physician or Professional Other Provider; and (2) are 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: (1) provided by a person employed by the directing Physician or Professional Other Provider; (2) provided at the usual place of business of the directing Physician or Professional Other Provider; and (3) 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:

1. Services of Physicians or Professional Other Providers, and in the case of a Licensed Dietitian, Certified Social Worker-Advanced Clinical Practitioner, Licensed Professional Counselor, or a Licensed Marriage and Family Therapist, a professional recommendation has been obtained from a Physician.
2. Services of a certified registered nurse-anesthetist.

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

4. Diagnostic x-ray and laboratory procedures.

5. Radiation therapy.

6. Drugs and medicines, including injectable drugs, purchased for use outside of a Hospital which require a written prescription for purchase in those limited quantities required for the immediate therapeutic needs of the Participant while covered under this Contract (not including Home Infusion Therapy items) up to a maximum benefit amount of \$1,000 per Participant each Calendar Year. Injectable insulin shall be limited to no more than four 10cc vials on any occasion when the insulin is dispensed. The quantity of disposable syringes and needles covered for self-administered injections shall be limited on each occasion dispensed to amounts appropriate to the dosage amounts of covered injectable drugs actually prescribed and dispensed, but cannot exceed 100 syringes and needles on any occasion dispensed. Benefits for charges deemed to be in excess of the Participant's own immediate therapeutic needs may be denied, or if already paid, will be recoverable upon later review.

7. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Carrier. The term "durable medical equipment" shall not include: (a) equipment primarily designed for alleviation of pain or provision of patient comfort; or (b) home air-fluidized bed therapy. Examples of noncovered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

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

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

10. Oxygen and its administration, provided the oxygen is actually used.

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

12. 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.



13. 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.

Noncovered items include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a nonhospital 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.

14. Home Infusion Therapy when the treatment plan is precertified by the Home Infusion Therapy Provider in accordance with the Carrier's established procedures. Any item of Home Infusion Therapy covered under this Subsection 14 will not be eligible for benefits under any other provision of this Contract.
15. Services or supplies used by the Participant during an outpatient visit to a Hospital or a Therapeutic Center.

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

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
3. Not primarily for the convenience of the Participant, his Physician, his Hospital, or his Other Provider; and
4. The most economical supplies or levels of services that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

The medical staff of the Carrier shall determine whether a service or supply is Medically Necessary and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician or Professional Other Provider may have

prescribed treatment, such treatment may not be Medically Necessary within this definition.

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

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

1. The diagnosis or treatment of a mental disease, disorder, or condition as defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual (DSM) III-R*, or any other diagnostic coding system as used by the Carrier, whether or not the cause of the disease, disorder or condition is physical, chemical, or mental in nature or origin;
2. The diagnosis or treatment of any symptom, condition, disease or disorder by a Physician or Professional Other Provider (or by any person working under the direction of a Physician or Professional Other Provider) when the Eligible Expense is:
  - a. Individual, group, family or conjoint psychotherapy,
  - b. Counseling,
  - c. Psychoanalysis,
  - d. Psychological testing and assessment,
  - e. The administration or monitoring of psychotropic drugs, or
  - f. Hospital visits or consultations in a facility listed in Subsection 5 of this Section AG;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in Subsections 1 through 4 of this Section AG performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

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

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



AJ. **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:

1. **Facility Other Provider** — an institution or entity, only as listed:
  - a. Home Health Agency
  - b. Home Infusion Therapy Provider
  - c. Hospice
  - d. Renal Dialysis Center
  - e. Skilled Nursing Facility
  - f. Therapeutic Center
2. **Professional Other Provider** — a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
  - a. Certified Social Worker-Advanced Clinical Practitioner
  - b. Doctor of Chiropractic
  - c. Doctor of Dentistry
  - d. Doctor of Optometry
  - e. Doctor of Podiatry
  - f. Doctor in Psychology
  - g. Licensed Audiologist
  - h. Licensed Dietitian
  - i. Licensed Hearing Aid Fitter and Dispenser
  - j. Licensed Marriage and Family Therapist
  - k. Licensed Professional Counselor
  - l. Licensed Speech-Language Pathologist

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.

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

AL. **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.

AM. **Physician** means a person, when acting within the scope of his license (other than a Hospital resident or intern), 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*.

AN. **Preexisting Condition** 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.

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

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and correct diagnosis code(s) and procedure code(s) for the services and items; and
3. Any other information reasonably necessary for the Carrier to process the claim or to determine its liability, if any, under this Contract including, but not limited to, medical records from a Provider(s), and provided at no expense to the Carrier.

When the Carrier requests information to process the claim or determine its liability, if any, under this Contract, Proof of Loss is not complete until such information is received in writing in the Home Office of the Carrier.

AP. **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).

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

AR. **Reasonable Charge** means the maximum allowable amount determined by the Carrier to be payable for a particular service, supply or procedure.

For services provided in Texas, Reasonable Charge is based on the lesser of the actual charge or the charge, as determined by the Carrier from data it has compiled, customarily made by Physicians or Professional Other Providers in the same locality with similar training, experience and facilities. The Carrier may, at its option, allow a higher charge than the customary charge if it deems it reasonable, or set a fee schedule providing for higher or lower charges than the customary charge based on data it has compiled, or use the time and points payment methodology of reimbursement. If the Carrier does not have sufficient data to calculate the

amount customarily charged, the Carrier will make a determination based on the complexity of the procedure, unusual circumstances or medical complications requiring additional time, skill, experience and facilities in connection with a particular service, which are specifically brought to the Carrier's attention.

For services performed outside of Texas, the Carrier will establish a Reasonable Charge using, at the Carrier's option, Dallas County or Texas statewide profiles of charges applicable to services by Physicians or Professional Other Providers with similar training, experience and facilities. The Carrier may, at its option, allow a higher charge if it deems it reasonable.

In the case of multiple surgeries performed through the same incision or in the same operative area for which there is not a unique single Reasonable Charge, the Reasonable Charge for all procedures combined will be an amount equal to the highest single procedure Reasonable Charge of the procedures performed plus one-half of the Reasonable Charge for each of the other procedures.

AS. **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.

AT. **Second Surgical Opinion Services** means services for a consultative opinion, including diagnostic testing, provided by a Physician or Professional Other Provider acting within the scope of his license when required by the Carrier to confirm the need for recommended surgery, provided such consultative opinion is given by a Physician or Professional Other Provider other than the Physician or Professional Other Provider who first recommended the surgery, is not given by the surgeon scheduled to perform the surgery, and such opinion is provided prior to the actual surgery.

AU. **Skilled Nursing Facility** means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which: (1) is licensed in accordance with state law (where the state law provides for licensing of such facility); and (2) is Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

AV. **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.

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

AX. **Therapeutic Center** means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is: (1) an ambu-

latory (day) surgery facility; or (2) a freestanding radiation therapy center.

## Article II — Effective Date of Dependent Coverage

### A. Newborn Child

Coverage of your child born after your Effective Date will automatically be in effect from the date of birth through the 31st day following the date of birth. For coverage to be in effect following such 31st day, the Carrier must receive notification from you on an enrollment form for Dependent addition within the first 31 days following date of birth. If you wait until after this 31-day period to add the child, the coverage will not become effective until the Carrier accepts the application as described in the paragraph below.

### B. Other Dependents

Coverage under this Contract for a Dependent (other than a newborn child) shall be contingent upon the Subscriber's making application for such coverage on a form approved by the Carrier. The application form and satisfactory evidence of insurability must be submitted to the Home Office of the Carrier. Subject to approval by the Carrier of the application, evidence of insurability, and the first full month's premium, coverage shall become effective as follows:

1. If a Dependent listed on the application is approved by the Carrier at the same time as the Subscriber, coverage is effective on the Effective Date of this Contract.
2. Coverage of all other Dependents shall become effective on the first day of the Contract Month following the date the Carrier approves the application.

## Article III — Payment of Benefits; Participant/Provider Relationship

### A. Payment of Benefits

1. Payment of benefits by the Carrier to the Provider furnishing the service or to the Subscriber, as the Carrier may elect, shall constitute full discharge of all responsibility of the Carrier to the Subscriber on account of benefits available to any Participant under this Contract.
2. The rights and benefits of this Contract shall not be assignable, either before or after services and supplies are provided.
3. It is understood and agreed that the allowances set out in Article IV for services and supplies furnished by a Provider, with whom the Carrier does not directly contract, are not intended to and do not fix the value of the services of the Provider nor in any way relate to or regulate such value; that such Provider is privileged to make its regular charges

and that the stipulated amounts are merely to apply as credits thereon.

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

## **B. Participant/Provider Relationship**

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

## **Article IV — Benefits Provided**

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

### **A. Precertification**

Precertification of care is the process which establishes in advance the Medical Necessity of services under this Contract. Precertification is required for each Hospital Admission, for any *Extended Care Expense*, and for Home Infusion Therapy.

Precertification ensures that the precertified care will not be denied on the basis of Medical Necessity. However, precertification does not guarantee payment of a claim. Coverage is always subject to other contractual requirements, such as Preexisting Condition limitations, at the time services are provided.

#### **1. Inpatient Precertification**

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

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

At the time inpatient precertification is requested, the Carrier will:

- a. Inform you and your Physician if a second surgical opinion is required. If required, the Carrier must receive notification that the second opinion has been obtained before it can further process the precertification request; and
- b. Assign a length-of-stay for the Hospital Admission if it determines that the Hospital Admission is Medically Necessary.

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

Failure to precertify in accordance with the Carrier's procedures will result in a \$250 penalty 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 the deductible or to apply to the Coinsurance Stop-Loss Amount.

#### **2. Extended Care Expense and Home Infusion Therapy Precertification**

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

In order for any benefits to be available for *Extended Care Expense* or Home Infusion Therapy, precertification must be obtained by having the Provider of the services submit a treatment plan to the Carrier on a Precertification Review Form. The Precertification Review Form must be completed:

- a. Before the start of *Extended Care Expense* or Home Infusion Therapy; and
- b. Every 30 days for recertification of *Extended Care Expense* or Home Infusion Therapy; and
- c. When the treatment plan is altered.

If *Extended Care Expense* or Home Infusion Therapy is to take place in less than one week, have the Provider call the Carrier at the telephone numbers shown on the reverse side of your identification card.

Information will be reviewed by the Carrier prior to the start of *Extended Care Expense* or Home Infusion Therapy. A letter will be sent to both you and the Provider of services indicating either benefit approval or denial of the treatment plan requested. If *Extended Care Expense* or Home Infusion Therapy is scheduled within 72 hours, the Provider will be notified of the Carrier's decision by phone. No benefits will be available for charges incurred when the corresponding treatment plan has been previously denied based on the information submitted.

## B. Deductible

1. The deductible amount indicated in the Subscriber's application for this Contract will be subtracted once during each Calendar Year from each Participant's total combined *Inpatient Hospital Expense* and/or *Medical-Surgical Expense* incurred for that Calendar Year.
2. When the total amount of the deductible incurred in a Calendar Year by Participants under the Subscriber's coverage equals three times the deductible amount indicated in the Subscriber's application for this Contract, all such Participants will have satisfied their deductible for the remainder of that Calendar Year. No Participant will be required to contribute more than the individual deductible to the family deductible amount.

## C. Benefits for Inpatient Hospital Expense

As explained previously, precertification is required for each Hospital Admission. If *Inpatient Hospital Expense* is incurred during each Hospital Admission in excess of the deductible specified in Section B, above, the Carrier will provide benefits equal to the amount determined by multiplying the remaining *Inpatient Hospital Expense* by 80%.

## D. Benefits for Medical-Surgical Expense

### 1. Benefit Determination

If *Medical-Surgical Expense* is incurred in excess of the deductible specified in Section B, above, the Carrier will provide benefits equal to the amount determined by multiplying the remaining *Medical-Surgical Expense* by 80%.

### 2. Exception

If any Participant incurs *Medical-Surgical Expense* for Second Surgical Opinion Services required by the Carrier to be obtained before certification of a Hospital Admission will be considered, the Carrier shall provide benefits equal to the Reasonable Charge for such expense. No deductible will be applicable to such expense.

## E. Benefits for Extended Care Expense

As explained previously, all *Extended Care Expense* requires precertification. No benefits are available unless the treatment plan is precertified. When *Extended Care Expense* has been precertified in accordance with the Carrier's procedures, benefits will be available as explained below.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will be considered *Medical-*

*Surgical Expense* and benefits will be determined as described in Section D, above.

The Carrier will provide benefits at 100% of the Reasonable Charge for the services and supplies listed below when rendered or provided by the Skilled Nursing Facility, Home Health Agency, or Hospice to a Participant in accordance with the precertified treatment plan, up to the following maximum Calendar Year or lifetime benefit amounts:

- Skilled Nursing Facility — \$5,000 benefit per Participant each Calendar Year;
- Home Health Agency Care — \$5,000 benefit per Participant each Calendar Year;
- Hospice Care — \$10,000 lifetime benefit per Participant.

The deductible will not be applicable to *Extended Care Expense*.

Charges must be billed for on forms acceptable to the Carrier.

Services and supplies for *Extended Care Expense*:

1. *Skilled Nursing Facility* — Charges are incurred during a precertified inpatient admission for:
  - 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 therapy, occupational therapy, speech therapy, and respiratory therapy by persons licensed to perform such services.
2. *Home Health Agency Care* — Charges are incurred during a precertified Home Health Agency visit for:
  - 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 therapy, occupational therapy, speech therapy, and respiratory therapy by persons licensed to perform such services;
  - d. Supplies and equipment routinely provided by the Home Health Agency.

Benefits will not be provided for Home Health Care services for:

- a. Food or home delivered meals;
- b. Social case work or homemaker services;
- c. Services rendered primarily for Custodial Care;
- d. Transportation services;
- e. Home Infusion Therapy.

3. **Hospice Care** — Charges incurred under a precertified Hospice Care treatment plan:

For Home Hospice Care:

- a. Part-time or intermittent nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical therapy, speech therapy, and respiratory therapy by persons licensed to perform such services;
- d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

For Institutional Hospice Care:

- a. All usual nursing care by a Registered Nurse (R.N.) or by a Licensed Vocational Nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
- c. Physical therapy, speech therapy, and respiratory therapy by persons licensed to perform such services.

**F. Benefits for Complications of Pregnancy/Maternity Care**

1. Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be the same as for treatment of sickness.
2. Unless the optional Maternity Care benefit has been selected, benefits for Maternity Care are not available under this Contract.
3. If the optional Maternity Care benefit has been selected, benefits for Eligible Expenses incurred for Maternity Care will be the same as for treatment of sickness except:
  - a. A deductible of \$1,000 in addition to the deductible contained in Section B of this Article IV will be subtracted from Eligible Expenses; and
  - b. No benefits are available until the expiration of two years from the effective date of the optional Maternity Care benefit; and
  - c. No benefits are available for Maternity Care of a Dependent child.
4. No benefits are available unless the patient is a Participant on the date services are provided, except as provided in Article VI, Section A, Subsection 6 of this Contract.

**G. Benefits for Mammography Screening**

If a female Participant of 35 years of age or older incurs *Medical-Surgical Expense* for a screening by low-dose mammography for the presence of occult breast can-

cer, benefits will be determined on the same basis as for other radiological examinations, except that benefits shall not be available for more than one mammography screening each Calendar Year.

**H. Benefits for Organ Transplants**

Benefits for Eligible Expenses incurred by a Participant (donor and/or recipient) related to an organ transplant will be determined on the same basis as any other sickness except to the extent modified below. "Related to" includes, but is not limited to, x-rays, laboratory, chemotherapy, radiation therapy, prescription drugs, and complications arising from the organ transplant.

1. Included within Eligible Expenses for a Participant are services provided:
  - a. For the evaluation of organs including, but not limited to, the determination of tissue matches;
  - b. For the removal of organs from deceased donors;
  - c. For the transportation and storage of donated organs.
2. No benefits are available for a Participant (donor and/or recipient) for the following expenses:
  - a. Living and/or travel expenses of the live donor or recipient;
  - b. Donor search and acceptability testing of potential living donors;
  - c. Expenses related to maintenance of life for purposes of organ donation.
3. No benefits are available unless the transplant procedure is for the:
  - a. Liver;
  - b. Heart;
  - c. Heart-Lung;
  - d. Kidney;
  - e. Cornea;
  - f. Bone Marrow;and then only if
  - (1) The transplant procedure is not Experimental/ Investigational in nature;
  - (2) Human organs are used;
  - (3) The donor and/or recipient is a Participant under this Contract.
4. The maximum lifetime benefit amount for each Participant is \$100,000. This maximum shall include benefits provided for prescription drugs used while hospital confined. Benefits provided for drugs used on an outpatient basis will be applied toward the maximum benefit amount specified in Article I, Section AD, Subsection 6, of this Contract.

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

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



"Well-Child Care" means a program of periodic physical examination, developmental assessment, and immunization (not including allergy injections) for a child through age seven.

*Medical-Surgical Expense* under this Section I for immunizations shall not be subject to a deductible.

#### **J. Coinsurance Stop-Loss**

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

#### **K. Large Case Management**

The Carrier, in its sole discretion, may elect to provide alternative benefits which are not otherwise Eligible Expenses under this Contract, provided: (1) the Participant, his family and the Participant's Physician concur; and (2) the benefits are cost effective; and (3) the Carrier anticipates future expenditures for Eligible Expenses for a Participant which may be reduced by providing alternative benefits. Any alternative benefits shall be determined on a case-by-case basis. The Carrier's determination to provide alternative benefits in one instance shall neither commit the Carrier to provide the same or similar alternative benefits for the same Participant or any other Participant nor cause the Carrier to waive its right to strictly apply the express provisions of this Contract in the future.

#### **L. Maximum Lifetime Benefits**

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

### **Article V — Limitations and Exclusions**

*The benefits 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 Reasonable Charge as determined by the Carrier.
- C. Any services or supplies for which benefits are, or could upon proper claim be, provided under the Work-

ers' Compensation law; or any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, except as provided in Article VIII, Section H; provided, however, this Section C 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 the approval of the Carrier 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.
- 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 furnished by a Noncontracting Facility (except that in accident cases, the immediate, initial treatment necessary to stabilize the Participant furnished by any Hospital, including a governmental facility, shall be subject to benefits as provided in Article IV of this Contract); or any services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with the Carrier.
- L. Any services or supplies provided during the course of a Hospital Admission or an admission in a Facility Other Provider which commences before the patient is covered as a Participant hereunder or any services or

supplies provided after the termination of the Participant's coverage, except as provided in Article VI, Section A, Subsection 6, of this Contract.

M. Any services or supplies provided for Dietary and Nutritional Services, except for a nutritional assessment program provided in and by a Hospital and approved in advance by the Carrier.

N. Any services or supplies for Custodial Care.

O. Any services or supplies provided in connection with a routine physical examination (including a routine Pap smear), diagnostic screening, or immunizations. This exclusion does not apply to mammography screening or to Well-Child Care as may be provided in Article IV of this Contract.

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

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

R. Any items of *Medical-Surgical Expense* incurred for dental care and treatments, dental surgery, or dental appliances, except for:

1. Covered Oral Surgery; or
2. Services provided to a Dependent child which are necessary for treatment or correction of a congenital defect; or
3. The correction of damage caused solely by external accidental injury to healthy, unrestored natural teeth and supporting tissues occurring while the Participant is covered under this Contract and limited to such services and supplies provided: (a) for 24 months from the date of the 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.

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

1. Treatment provided for the correction of defects incurred in an accidental injury sustained by the Participant while covered under this Contract; or
2. Treatment provided for reconstructive surgery following neoplastic (cancer) surgery while the Participant is covered under this Contract; or

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

T. Any services or supplies provided for:

1. Treatment of myopia and other errors of refraction, including refractive surgery; or
2. Orthoptics or visual training; or
3. Eyeglasses, contact lenses or hearing aids, provided that intraocular lenses and cochlear implant devices shall be specific exceptions to this exclusion; or
4. Examinations for the prescription or fitting of eyeglasses, contact lenses or hearing aids, except as may be provided under "Benefits for Well-Child Care."

U. Mental Health Care.

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.

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.

Y. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multidisciplinary 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.

AB. 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.
- AC. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
- AD. 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.
- AE. 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:
      - (1) Has a marked limitation of ambulation requiring active treatment of the foot; or
      - (2) In the case of a nonambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment; and
  4. Excision of a nail without using an injectable or general anesthetic.
- AF. 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.
- AG. Any services or supplies provided to any Participant for Maternity Care, unless the optional Maternity Care benefit has been selected.
- AH. Any Speech and Hearing Services except for: (1) *Extended Care Expense*; and (2) Well-Child Care as provided in Article IV of this Contract.
- AI. Any services or supplies provided during the first 24 months following the Effective Date of the Participant's coverage under this Contract which were incurred as the result of a Preexisting Condition.
- AJ. Any services or supplies for reduction mammoplasty.
- AK. Any smoking cessation prescription drug products, including, but not limited to, nicotine gum or nicotine patches.
- AL. Any services or supplies not specifically defined as Eligible Expenses herein.

#### Article VI — Termination of Coverage

- A. The coverage of the Subscriber and all covered Dependents under this Contract will terminate on the earliest of the following dates:
1. On the last day of the last period for which the premium for this Contract has been paid to the Carrier, subject to the grace period provided in Article VII, Section C; or
  2. On the last day of any Contract Month on written request for termination of this Contract made by the Subscriber and received by the Carrier prior thereto; or
  3. On the date of death of the Subscriber; or
  4. On the last day of the Contract Month in which the Subscriber becomes 65 years of age, provided that coverage shall not terminate under this Subsection 4 prior to the last day of the last period for which premiums have been paid to and accepted by the Carrier; or
  5. On the last day of any Contract Month in which a Subscriber establishes residency outside the State of Texas; or
  6. On the first day of any Contract Month upon 60 days advance notice by the Carrier to the Subscriber, but only if it is then terminating in like fashion all other Form No. SEL-4 Select 2000™ Plan Contracts; provided that under this Subsection 6 coverage for any continuous illness or injury which commenced while this Contract was in force shall, at termination, continue during the continuous Total Disability of the Participant until the earliest of:
    - a. The end of the Calendar Year;
    - b. Payment of maximum benefits under this Contract; or
    - c. The end of 90 days.

"Total Disability," for purposes of this Subsection 6, means the complete inability of the Subscriber or, if applicable, the Subscriber's spouse, as a result of injury, sickness, or pregnancy, 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. "Total Disability" of a Dependent other than the Subscriber's spouse, for purposes of this Subsection 6, means confinement as a bed patient in a hospital.

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

1. At the end of the Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section K, of this Contract, provided that if such date falls within a period for which premium has been accepted by the Carrier, coverage shall not terminate until the last day of such period; or
2. On the date of death of the Dependent; or
3. On the last day of any Contract Month on written request for termination of the Dependent's coverage made by the Subscriber and received by the Carrier prior thereto; or
4. On the last day of any Contract Month in which a Dependent establishes residency outside the State of Texas.

C. Notwithstanding the provisions of Section A, above, within 30 days of the death or attainment of age 65 of the Subscriber, all remaining eligible Dependents under age 65 may jointly elect in written notice to the Carrier to continue this Contract with the eldest Dependent as Subscriber. The Carrier will determine the appropriate premium adjustment, if any.

D. Notwithstanding the provisions of Section B, above, within 30 days of a divorce, marriage of a child, or a child attaining age 23, the former Dependent losing coverage may elect to apply for coverage in his own name. Upon timely application, the Carrier shall afford coverage in 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. The new Contract will have the same effective date as the Contract under which coverage was afforded prior to the loss of coverage. The rights provided under this Section D shall terminate if no application is received by the Carrier within the 30-day period.

#### Article VII — Standard Provisions

A. **Claim Forms:** The Carrier will furnish to the Subscriber, the Hospital, and/or the Participant's Physician

or Professional Other Provider, upon receipt of a notice of claim or prior thereto, such forms as are usually furnished by it for filing Proof of Loss. If such forms are not furnished within 15 days after receipt of such notice by the Carrier, the Participant shall be deemed to have complied with the requirements of this Contract as to Proof of Loss upon submitting, within the time fixed in the Contract for filing such Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

#### B. **Contract; Amendments:**

1. 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.
2. Only the President, a Vice President, the Secretary, or an Assistant Secretary of the Carrier has the power to change, modify, or waive the provisions of this Contract, and then only in writing done at the Home Office and attached or endorsed hereto. The Carrier shall not be bound by any promise or representation heretofore or hereafter made by or to any agent other than as specified above.

C. **Grace Period:** A grace period of ten days for the 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.

D. **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.

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

F. **Notice of Claim:** The Subscriber shall give or cause to be given written notice to the Home Office of the Carrier at Richardson, Dallas County, Texas or its duly authorized agent within 30 days or as soon as reasonably possible after any Participant receives any of the

services for which benefits are provided herein. Notice given to any Hospital at the time of admission therein as a patient shall satisfy this requirement.

**G. Physical Examinations and Autopsy:** The Carrier at its own expense shall have the right and opportunity to examine the person of the Participant for whom claim is made, when and so often as it 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.

**H. Proof of Loss:**

1. Except for services or supplies provided by a Contracting Facility, written Proof of Loss must be furnished to the Home Office of the Carrier at Richardson, Dallas County, Texas, or its duly authorized agent, no later than 90 days from the date that the services or supplies are provided to the Participant. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity of the Subscriber, later than one year from the time proof is otherwise required.
2. Written Proof of Loss for services or supplies provided by a Contracting Facility must be furnished to the Carrier by the Contracting Facility in strict compliance with the written contract between the Carrier or another Blue Cross Plan and the Contracting Facility. In the event such written contract does not contain a time limitation for furnishing Proof of Loss, the provisions of Subsection 1, above, shall be applicable.

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

not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

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

1. 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.
2. 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 2 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**

**A. Applicable Law:** This Contract is issued in Texas and is subject to Texas choice of law rules.

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

**C. Disclosure Authorization:**

1. In consideration of the Carrier's having waived physical examination in connection with the application herefor, the Subscriber, on behalf of himself and his covered Dependents, shall be deemed to have authorized any attending Physician or Professional Other Provider or Hospital to furnish the Carrier all information and records or copies of records relating to the diagnosis, treatment, or care of any Participant included under this Contract; and such Participants shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

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

**D. 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.

**E. Premiums:**

1. The premium applicable to this Contract is determined by the sex of the Subscriber, his age, his place of residence on each premium due date, the number and classification of the family members covered hereunder and the optional Maternity Care benefit, if applicable, in accordance with the schedules filed with the Texas Department of Insurance.

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

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

2. Notwithstanding the above provisions of Subsection 1, above, of this Section E:

a. **Change in Premium Upon Notice:** The Carrier reserves the right to adjust the premium upon 30 days notice to the Subscriber. Such adjustments in rates shall become effective on the date specified in said notice even though premiums have been accepted by the Carrier for periods subsequent to such date, but without prejudice to any claim prior to such date. 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 Paragraphs b and/or c, below, no adjustment in premium rate shall be made within six months of a previous adjustment in premium rate.

b. **Change of Residence:** If the Subscriber changes his place of residence and such change results in a change in premium, the premium applicable to this Contract shall automatically change to the rate applicable to the new place of residence effective on the first day of the Contract Month following the date of change of residence; provided that if such change is to a lower premium rate and the Subscriber fails to notify the Carrier in writing of such change prior to the date of change, the Subscriber's right to refund of overpayment shall be limited to the overpayment for the six

months immediately preceding the date of notification to the Carrier.

- c. **Age:** If the Subscriber attains an age which results in an increased premium rate, the premium applicable to this Contract shall automatically change to the rate applicable to the new age effective on the first day of the Contract Month following the Subscriber's birthday.

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

**G. Review of Claim Determinations:**

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

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

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

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

- a. Submit a written request for review mailed to the Carrier's Home 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.
- b. Include in the written request the items of concern regarding the Carrier's determination and must include 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 it, the Carrier will review its prior determination for correctness and make a new determination. The Participant will be notified in writing of the Carrier's decision and the reasons for it within 60 days of the Carrier's receipt of the request for review. This determination will be final unless additional information which has not previously been available for review is provided within 60 days of the Participant's receipt of the determination.

3. No lawsuit or action in law or equity may be brought by a Participant or on his behalf unless:
  - a. As a condition precedent, the Participant (or a parent if he is a minor) has first fully complied with all of the provisions of this Contract, including all of the requirements of this Section G, and specifically those in Subsection 2, above, for review of claim determinations; or
  - b. The Carrier has either denied in writing his request for review of the claim determination or has not provided a written response to the Participant's request for review within 60 days following receipt of the Participant's request for review.

#### H. State Government Programs:

1. 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*.
2. All benefits paid on behalf of a child or children under this Contract must be paid to the Texas Department of Human Services where:
  - a. The Texas Department of Human Services is paying benefits pursuant to Chapter 31 or 32 of the *Human Resources Code*; and
  - b. The parent who 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
  - c. The Carrier receives written notice at its Home 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.

provided hereunder, but only to the extent of the benefits so provided. Any Participant, by receiving benefits hereunder in such case, shall be deemed to have assigned such rights of recovery to the Carrier and to have agreed to do whatever may be necessary to secure the recovery, including execution of all appropriate papers.

- I. **Subrogation:** The Carrier shall be subrogated to all rights of recovery which any Participant may acquire against any person or organization for negligence or any willful act resulting in illness or injury for which benefits are

## 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.

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



## *Your Privacy with Blue Cross and Blue Shield of Texas*

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

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

### *Confidentiality and Security*

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

### *Information That May Be Collected*

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

### *Independent Insurance Agents*

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



BlueCross BlueShield  
of Texas

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

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

### **BlueCard Program Savings**

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

When you obtain health care services outside Texas and through the BlueCard Program, the Coinsurance Amount or co-share amount you pay is calculated based on either the billed charge the Provider of health care charges for your covered services, or the "negotiated price" that the local Blue Cross and/or Blue Shield Plan passes on to Blue Cross and Blue Shield of Texas<sup>1</sup> ("BCBSTX"), whichever is *less*.

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

### ***What's a "negotiated price"?***

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

### ***Give me an example of how you calculate my liability.***

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

### ***Does BlueCard always work this way?***

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

<sup>1</sup>Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation,  
A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

## **Policyholder Liability Notice**

The following section is added to and made a part of the individual policy currently in force between Blue Cross and Blue Shield of Texas<sup>1</sup> ("BCBSTX") and the Policyholder/Subscriber, or the Benefit Booklet describing the benefits for participants of employer or association-sponsored medical plans:

### **Calculation of Participant Coinsurance Liability**

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

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

The negotiated rate may represent:

1. the actual price paid on the claim,
2. an estimated price that reflects adjusted aggregate payments expected to result from settlements or other non-claims transactions with one or more of the local Plan's health care Providers, or
3. a discount from billed charges representing the local Plan's expected average savings for all of its Providers or for a specified group of Providers.

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

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

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

<sup>1</sup>Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation,  
A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

## NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

## **An Amendment**

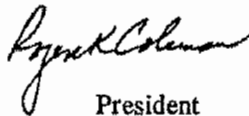
To be inserted in your Blue Cross and Blue Shield of Texas "Select 2000" Contract describing your individual insurance plan

Your Contract is amended as follows:

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

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

  
President

Attest:

  
Secretary

## An Amendment

**To be inserted in your Blue Cross and Blue Shield of Texas, Inc.\* "Select 2000" Contract describing your individual insurance plan**

Your Contract is amended as follows:

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

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

2. Article I of this Contract is amended by adding the following new Definitions:

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

1. A self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or
2. Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; or
3. Part A or Part B of Title XVII of the Social Security Act (Medicare); or
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; or
5. Chapter 55 of Title 10, United States Code; or
6. A medical care program of the Indian Health Service or of a tribal organization; or
7. A state health benefits risk pool; or
8. A plan offered under Chapter 89 of Title 5, United States Code; or
9. A public health plan as defined by federal regulations; or
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C., Section 2504(e)).

***Creditable Coverage does not include:***

1. Accident only, disability income insurance, or a combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Credit-only insurance;
6. Coverage for onsite medical clinics;
7. Coverage for limited-scope dental or vision benefits;

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

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;

**Health Status Related Factor means:**

1. Health status;
  2. Medical condition, including both physical and mental illness;
  3. Claims experience;
  4. Receipt of health care;
  5. Medical history;
  6. Genetic information;
  7. Evidence of insurability, including conditions arising out of acts of family violence; and
  8. Disability.
3. Article V of this Contract is amended by deleting the wording of Section AI in its entirety and substituting the following:
- AI. Any services or supplies for Eligible Expenses incurred for a Preexisting Condition during a period of 24 months beginning with the Participant's Effective Date under this Contract. This Preexisting Condition exclusion shall not apply to a Participant:
1. Who was continuously covered for an aggregate of 18 months under Creditable Coverage if the previous coverage was in effect up to a date not more than 63 days before the Effective Date of the Participant's coverage under this Contract, excluding any waiting periods; and
  2. Whose most recent Creditable Coverage was under a group health plan, governmental plan or church plan.
- We will credit the time You were previously covered under Creditable Coverage if the previous coverage was in effect at any time during the 18 months preceding the Effective Date of coverage under this Contract.
4. Article VI of this Contract is deleted in its entirety and replaced with the following:

**Article VI — Termination of Coverage**

- A. The coverage of the Subscriber and all covered Dependents under this Contract will terminate on the earliest of the following dates:
1. On the last day of the last period for which the premium for this Contract has been paid to the Carrier, subject to the grace period provided in Article VII, Section C; or

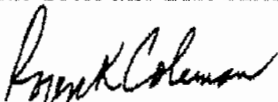


2. On the last day of any Contract Month upon written request for termination of this Contract made by the Subscriber and received by the Carrier prior thereto; or
  3. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
  4. On the date of death of the Subscriber; or
  5. On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor; or
  6. On the first day of any Contract Month upon 60 days advance notice by the Carrier to the Subscriber, but only if it is then terminating in like fashion all other Form No. SEL-4 Select 2000<sup>SM</sup> Plan Contract; provided that under this Subsection 6:
    - a. Coverage for any continuous illness (except for pregnancy) or injury which commenced while this Contract was in force shall, at termination, continue during the continuous Total Disability of the Participant until the earliest of:
      - (1) The end of the Calendar Year; or
      - (2) Payment of maximum benefits under this Contract; or
      - (3) The end of 90 days."Total Disability," for purposes of this Subsection 6, means the complete inability of a Participant as a result of injury or sickness to perform the usual tasks of his occupation, provided such Participant is not otherwise gainfully employed for wage or profit and is under the regular care of a Physician or Professional Other Provider.
    - b. Coverage for pregnancy which commenced while this Contract was in force and for which benefits would have been available, shall at termination, continue to the end of such pregnancy.
- B. In addition to the provisions of Section A, above, the coverage of any Dependent under this Contract shall terminate on the earliest of the following dates:
1. At the end of the Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section K, of this Contract, provided that if such date falls within a period for which premium has been accepted by the Carrier, coverage shall not terminate until the last day of such period; or
  2. On the date of death of the Dependent; or
  3. On the last day of any Contract Month on written request for termination of the Dependent's coverage made by the Subscriber and received by the Carrier prior thereto; or
  4. On the last day of any Contract Month in which a Dependent no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor.
- C. Notwithstanding the provisions of Section A, above, within 30 days of the death of the Subscriber, all remaining eligible Dependents may jointly elect in written notice to the Carrier to continue this Contract with the eldest Dependent as Subscriber.
- D. Notwithstanding the provisions of Section B, above, within 30 days of a divorce, marriage of a child, or a child attaining age 23, the former Dependent losing coverage may elect to apply for coverage in his own name.

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

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

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

  
Rogers K. Coleman, President

### **Exclusion Riders**

**When issuing Exclusion Riders with Form No. SEL-4 Plan Contract for specific health conditions, the following descriptions will be used for new contracts issued on and after 8-1-97.**

1. Any injury to or disease of the lumbar, lumbosacral, sacroiliac spine including nerves and muscles thereof; or sciatic
2. Any injury to or disease of the cervical spine including nerves and muscles thereof
3. Any injury to or disease of the dorsal spine including nerves and muscles thereof
4. Any injury to or disease of the spinal column including nerves and muscles thereof
5. Any injury to or disease of the (affected) area
6. Any injury to or disease of the (affected joint)
7. Any injury to or disease of either or both (affected joints)
8. Any injury to or disease of the (affected member)
9. Any injury to or disease of the coccyx
10. Any injury to or disease of the (affected bone[s])
11. Any injury to or disease of the (affected bone); or osteomyelitis
12. Any injury to or disease of the (affected member or area); or any corrective procedure for poliomyelitis
13. Any injury to or disease of the stump of (affected member)
14. Any disease of the (affected area)
15. Any disease of either or both breasts
16. Any disease of the (affected joint); or bursitis
17. Any disease of the colon
18. Any disease of the (affected eye)
19. Any disease of the affected eye; or cataract
20. Any disease of either or both eyes
21. Any disease of the gall bladder or bile ducts
22. Any disease of the (affected kidney) or ureter
23. Any disease of the larynx
24. Any disease of the liver or biliary tract; or jaundice
25. Any disease of the lungs or pleura

26. Any disease of the parotid gland
27. Any disease of the prostate gland
28. Any disease of the rectum or anus
29. Any disease of the salivary glands
30. Any disease of the skin
31. Any disease of the skin or subcutaneous tissue
32. Any disease of the stomach, duodenum, or jejunum
33. Any disease of the esophagus or stomach
34. Any disease of the teeth or gums
35. Any disease of the testicle
36. Any disease of the removal of the tonsils or adenoids
37. Any disease of the thyroid gland
38. Any disease of the urinary tract
39. Any disease of the urinary bladder or urethra
40. Any disease of the uterus or adnexa
41. Any disease of the uterus, adnexa, or genital relaxations
42. Any corrective procedure to the (affected eye); or (exotropia) (strabismus)
43. Any corrective procedure for impaired hearing; or otosclerosis
44. Any tumor or neoplasm or metastasis
45. Any neoplasm of the (skin) (nasal passages or paranasal sinuses) (urinary bladder) (urethra) (affected bone) (mucous membrane)
46. Any staphylococcus infection of the skin
47. Complications of pregnancy which commenced prior to effective date of this policy
48. Injury or disease due to participation in (the particular sport) activities
49. Acne
50. Abdominal adhesion or intestinal obstruction
51. Appendicitis
52. Asthma, bronchitis, or allergy

53. Asthma, bronchitis, or bronchiectasis
54. (Appropriate) cyst
55. Cleft palate; or hare lip
56. Conjunctivitis
57. Dermatitis
58. Deviated nasal septum
59. Erysipelas
60. Facial paralysis
61. Hemangioma
62. Hemorrhoids
63. Hernia at sight of (indicate previous surgery)
64. (Appropriate) hernia
65. Herpes Zoster
66. Histoplasmosis
67. Hives, urticaria or angioneurotic edema
68. Hydrocele
69. Keratosis
70. Kidney stones or kidney colic
71. Lipoma
72. Migraine headaches
73. Malaria
74. Neuroma
75. Otitis externa
76. Otitis media of mastoiditis of either or both ears
77. Pilonidal cyst or pilonidal sinus
78. Plantar Wart
79. Pneumothorax
80. Pterygium

81. Previous hysterectomy
82. Scalenus anticus syndrome
83. Sinusitis
84. Spermatocoele
85. Treatment of nervous or mental diseases or deficiencies, psychotic or psychoneurotic disabilities or reactions
86. Undulant fever
87. Varicocele
88. Varicose veins or phlebitis
89. Any disease or disorder of the respiratory system
90. Caesarean section
91. Any hormone replacement care or treatment
92. Any disease or disorder of either or both ears
93. Any disease or disorder relating to eye prosthesis
94. Any disease or disorder relating to menopausal syndrome
95. Any disease or disorder relating to arthritis, neuritis, neuralgia, or rheumatism
96. Bunions
97. Cystocele
98. Any liability relating to infertility
99. Ganglion Cyst
100. Disease or disorder of the cardiovascular system
101. Implants of artificial material
102. Disease or disorder of the male or female genital system
103. Fistula
104. Sexually transmitted diseases

## An Amendment

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

1. Wherever the term "Reasonable Charge" appears in your Contract it is hereby replaced with "Allowable Amount."
2. Article I of the Contract is amended by deleting the definition of "**Reasonable Charge**" and replacing it with the following:

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

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

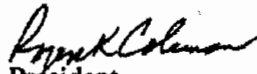
If BCBSTX does not have sufficient data to calculate the Allowable Amount for a particular procedure, service or supply, BCBSTX will determine an Allowable Amount based on the complexity of the procedure, service or supply and any unusual circumstances or medical complications specifically brought its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

4. For procedures, services or supplies performed outside Texas by Physicians or Professional Other Providers not contracting with BCBSTX or any other Blue Cross and Blue Shield Plan, BCBSTX will establish an Allowable Amount using, at its option, Dallas County or Texas statewide profiles of charges applicable to procedures, services or supplies of Physicians or Professional Other Providers with similar skills and experience.
5. For multiple surgeries, if there is not a unique Allowable Amount for multiple surgeries performed through the same incision or in the same operative area, the Allowable Amount for all procedures combined will be the amount for the single procedure with the highest Allowable Amount *plus* one-half of the Allowable Amount *for each* of the other procedures performed.
6. For drugs administered by a Home Infusion Therapy Provider, the Allowable Amount will be the lesser of (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage markup. AWP means the average wholesale price of a drug on the date the drug is administered by the Home Infusion Therapy Provider. The AWP is taken from nationally recognized sources in current use.



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

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

  
President

## An Amendment

Effective January 1, 1998

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

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

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

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

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

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

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

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

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

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

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

- e. Adding the following new definitions:

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

1. A self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or
2. Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; or
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare); or

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

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

***Creditable Coverage does not include:***

1. Accident only, disability income insurance, or a combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Credit-only insurance;
6. Coverage for onsite medical clinics;
7. Coverage for limited-scope dental or vision benefits;
8. Long-term care, nursing home care, home health care, or community-based care coverage or benefits, or any combination thereof;
9. Coverage for a specified disease or illness;
10. Hospital indemnity or other fixed indemnity insurance; or
11. Medicare supplemental health insurance, supplemental to the group coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et. seq.), and similar supplemental coverage provided under a group plan; and
12. Other similar coverage specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

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

1. Diabetic Equipment
  - a. Blood glucose monitors,
  - b. Insulin pumps and necessary accessories,
  - c. Insulin infusion devices, and
  - d. Podiatric appliances for the prevention of complications associated with diabetes.
2. Diabetic Supplies
  - a. Test strips for blood glucose monitors,
  - b. Visual reading and urine test strips,
  - c. Lancets and lancet devices,
  - d. Insulin and insulin analogs,
  - e. Injection aids, and

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

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

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

**Health Status Related Factor** means:

- 1. Health status;
  - 2. Medical condition, including both physical and mental illness;
  - 3. Claims experience;
  - 4. Receipt of health care;
  - 5. Medical history;
  - 6. Genetic information;
  - 7. Evidence of insurability, including conditions arising out of acts of family violence; and
  - 8. Disability.
3. Article IV, Section A, of the Contract is amended by deleting the wording of Subsection 1 in its entirety and substituting the following:

**1. Inpatient Precertification**

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

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

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

- a. If the Maternity Care Option was selected,
  - (1) 48 hours following an uncomplicated vaginal delivery; and
  - (2) 96 hours following an uncomplicated delivery by caesarean section.

b. Treatment of Breast Cancer,

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

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

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

4. Article IV, Section D, is amended by deleting the wording of Subsection 2 in its entirety.
5. Article IV of the Contract is amended by deleting the wording of the subsection entitled "Benefits for Well-Child Care" in its entirety and substituting the following:

**Benefits for Well-Child Care**

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

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

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

**Childhood Immunizations**

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

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

Allergy injections are not considered immunizations under this benefit provision.

**Certain Tests for the Detection of Prostate Cancer**

If a male Participant incurs *Medical-Surgical Expense* for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be determined on the same basis as for any other sickness. Benefits will only be provided for:

- (1) A physical examination for the detection of prostate cancer; and
  - (2) A prostate-specific antigen test used for the detection of prostate cancer for each male Participant under this Contract who is at least:
    - (a) 50 years of age and asymptomatic; or
    - (b) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.
7. Article V of the Contract is amended by deleting the wording of Section O in its entirety and substituting the following:
- O. Any services or supplies provided in connection with a routine physical examination (including a routine Pap smear), diagnostic screening, or immunizations. This exclusion does not apply to:
- a. Mammography screening,
  - b. Well-Child Care,
  - c. Childhood Immunizations, and
  - d. Certain tests for the detection of prostate cancer.
8. Article V of this Contract is amended by deleting the wording of Section S in its entirety and substituting the following:
- S. Any services or supplies provided for Cosmetic, Reconstructive or Plastic Surgery, except for the following:
- (1) Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant while covered under this Contract; or
  - (2) Treatment provided for reconstructive surgery following cancer surgery while the Participant is covered under this Contract; or
  - (3) Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
  - (4) Surgery performed on a Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast.
  - (5) Surgical reconstruction of a breast on which mastectomy surgery has:
    - (a) Been performed; and
    - (b) Not been performed.
- Surgical reconstruction of the breast* means the services or supplies necessary to restore or achieve breast symmetry.
9. Article V of this Contract is amended by deleting the wording of Section AI in its entirety and substituting the following:
- AI. Any services or supplies for Eligible Expenses incurred for a Preexisting Condition during a period of 24 months beginning with the Participant's Effective Date under this Contract. This Preexisting Condition exclusion shall not apply to a Participant:
1. Who was continuously covered for an aggregate of 18 months under Creditable Coverage if the previous coverage was in effect up to a date not more than 63 days before the Effective Date of the Participant's coverage under this Contract, excluding any waiting periods; and
  2. Whose most recent Creditable Coverage was under a group health plan, governmental plan or church plan.

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

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

#### Article VI — Termination of Coverage

- A. The coverage of the Subscriber and all covered Dependents under this Contract will terminate on the earliest of the following dates:
1. On the last day of the last period for which the premium for this Contract has been paid to the Carrier, subject to the grace period provided in Article VII, Section C; or
  2. On the last day of any Contract Month upon written request for termination of this Contract made by the Subscriber and received by the Carrier prior thereto; or
  3. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
  4. On the date of death of the Subscriber; or
  5. On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor; or
  6. On date following 90 days advance notice by the Carrier to the Subscriber, but only if it is then terminating in like fashion all other Form No. SEL-4 Select 2000<sup>SM</sup> Plan Contract; provided that under this Subsection 6:
    - a. Coverage for any continuous illness (except for pregnancy) or injury of a Participant which commenced while this Contract was in force shall, at termination, continue during the continuous Total Disability of the Participant to:
      - (1) The duration of the policy benefit period.
      - (2) Payment of maximum benefits under this Contract, or
      - (3) To a period of not less than 90 days."Total Disability," for purposes of this Subsection 6, means the complete inability of a Participant as a result of injury or sickness to perform the usual tasks of his occupation, provided such Participant is not otherwise gainfully employed for wage or profit and is under the regular care of a Physician or Professional Other Provider.
    - b. Coverage for pregnancy which commenced while this Contract was in force and for which benefits would have been available, shall at termination, continue to the end of such pregnancy.
- B. In addition to the provisions of Section A, above, the coverage of any Dependent under this Contract shall terminate on the earliest of the following dates:
1. At the end of the Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section K, of this Contract, provided that if such date falls within a period for which premium has been accepted by the Carrier, coverage shall not terminate until the last day of such period; or
  2. On the date of death of the Dependent; or




3. On the last day of any Contract Month on written request for termination of the Dependent's coverage made by the Subscriber and received by the Carrier prior thereto; or
  4. On the last day of any Contract Month in which a Dependent no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor.
- C. Notwithstanding the provisions of Section A, above, within 30 days of the death of the Subscriber, all remaining eligible Dependents may jointly elect in written notice to the Carrier to continue this Contract with the eldest Dependent as Subscriber.
- D. Notwithstanding the provisions of Section B, above, within 30 days of a divorce, marriage of a child, or a child attaining age 23, the former Dependent losing coverage may elect to apply for coverage in his own name.

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

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

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

  
President

## An Amendment

Effective January 1, 1998

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

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

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

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

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

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

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

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

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

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

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

- e. Adding the following new definitions:

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

1. A self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or
2. Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; or
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare); or

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

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

***Creditable Coverage does not include:***

1. Accident only, disability income insurance, or a combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Credit-only insurance;
6. Coverage for onsite medical clinics;
7. Coverage for limited-scope dental or vision benefits;
8. Long-term care, nursing home care, home health care, or community-based care coverage or benefits, or any combination thereof;
9. Coverage for a specified disease or illness;
10. Hospital indemnity or other fixed indemnity insurance; or
11. Medicare supplemental health insurance, supplemental to the group coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et. seq.), and similar supplemental coverage provided under a group plan; and
12. Other similar coverage specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

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

a. Diabetic Equipment

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

b. Diabetic Supplies

- (1) Test strips for blood glucose monitors,
- (2) Visual reading and urine test strips,
- (3) Lancets and lancet devices,
- (4) Insulin and insulin analogs,
- (5) Injection aids, and

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

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

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

**Health Status Related Factor** means:

1. Health status;
  2. Medical condition, including both physical and mental illness;
  3. Claims experience;
  4. Receipt of health care;
  5. Medical history;
  6. Genetic information;
  7. Evidence of insurability, including conditions arising out of acts of family violence; and
  8. Disability.
3. Article IV, Section A, of the Contract is amended by deleting the wording of Subsection 1 in its entirety and substituting the following:

**1. Inpatient Precertification**

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

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

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

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

Failure to precertify will result in a penalty in the amount of \$250 which will be deducted from any benefits which may be finally determined to be available for the Hospital Admission. This penalty amount cannot be used to satisfy

7. Article V of the Contract is amended by deleting the wording of Section O in its entirety and substituting the following:

- O. Any services or supplies provided in connection with a routine physical examination (including a routine Pap smear), diagnostic screening, or immunizations. This exclusion does not apply to:
- a. Mammography screening,
  - b. Well-Child Care,
  - c. Childhood Immunizations, and
  - d. Certain tests for the detection of prostate cancer.

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

- S. Any services or supplies provided for Cosmetic, Reconstructive or Plastic Surgery, except for the following:
- (1) Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant while covered under this Contract; or
  - (2) Treatment provided for reconstructive surgery following cancer surgery while the Participant is covered under this Contract; or
  - (3) Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
  - (4) Surgery performed on a Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast.
  - (5) Surgical reconstruction of a breast on which mastectomy surgery has:
    - (a) Been performed; and
    - (b) Not been performed.

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

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

- AI. Any services or supplies for Eligible Expenses incurred for a Preexisting Condition during a period of 24 months beginning with the Participant's Effective Date under this Contract. This Preexisting Condition exclusion shall not apply to a Participant:
1. Who was continuously covered for an aggregate of 18 months under Creditable Coverage if the previous coverage was in effect up to a date not more than 63 days before the Effective Date of the Participant's coverage under this Contract, excluding any waiting periods; and
  2. Whose most recent Creditable Coverage was under a group health plan, a governmental plan or a church plan.

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

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

### **Article VI — Termination of Coverage**

- A. The coverage of the Subscriber and all covered Dependents under this Contract will terminate on the earliest of the following dates:
1. On the last day of the last period for which the premium for this Contract has been paid to the Carrier, subject to the grace period provided in Article VII, Section C; or
  2. On the last day of any Contract Month upon written request for termination of this Contract made by the Subscriber and received by the Carrier prior thereto; or
  3. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
  4. On the date of death of the Subscriber; or
  5. On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor; or
  6. On the date following 90 days advance notice by the Carrier to the Subscriber, but only if it is then terminating in like fashion all other Form No. SEL-4 Select 2000<sup>SM</sup> Plan Contract; provided that under this Subsection 6, coverage for any continuous illness (except for pregnancy) or injury of a Participant which commenced while this Contract was in force shall, at termination, continue during the continuous Total Disability of the Participant to:
    - (1) The duration of the policy benefit period, or
    - (2) Payment of maximum benefits under this Contract, or
    - (3) To a time period of not less than 90 days.

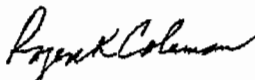
"Total Disability," for purposes of this Subsection 6, means the complete inability of a Participant as a result of injury or sickness to perform the usual tasks of his occupation, provided such Participant is not otherwise gainfully employed for wage or profit and is under the regular care of a Physician or Professional Other Provider.
- B. In addition to the provisions of Section A, above, the coverage of any Dependent under this Contract shall terminate on the earliest of the following dates:
1. At the end of the Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section K, of this Contract, provided that if such date falls within a period for which premium has been accepted by the Carrier, coverage shall not terminate until the last day of such period; or
  2. On the date of death of the Dependent; or
  3. On the last day of any Contract Month on written request for termination of the Dependent's coverage made by the Subscriber and received by the Carrier prior thereto; or
  4. On the last day of any Contract Month in which a Dependent no longer resides, lives, or works in an area for which the Carrier is authorized to do business; but only if coverage is terminated uniformly without regard to any Health Status Related Factor.
- C. Notwithstanding the provisions of Section A, above, within 30 days of the death of the Subscriber, all remaining eligible Dependents may jointly elect in written notice to the Carrier to continue this Contract with the eldest Dependent as Subscriber.

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

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

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

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

  
President



## An Amendment

Effective January 1, 2003

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

*Your Contract is amended as follows:*

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

- Surgical Assistant

*Patricia Hemingway Hall*

President

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

Name Change Endorsement


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

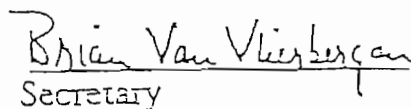
Blue Cross and Blue Shield of Texas, Inc.  
has changed its name as a result of a merger with  
Health Care Service Corporation, a Mutual Legal Reserve Company  
d/b/a Blue Cross and Blue Shield of Illinois, which does business in Texas as  
Blue Cross and Blue Shield of Texas,  
a Division of Health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

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

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

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

  
President

  
Secretary

## An Amendment

Effective January 1, 2000

To be attached to and made a part of your Blue Cross and Blue Shield Select 2000<sup>SM</sup> 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 subsection entitled Benefits for Cosmetic, Reconstructive, or Plastic Surgery is amended by deleting the 5<sup>th</sup> bullet in its entirety and substituting the following:
    - 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:
    - 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.

## An Amendment

Effective January 1, 2005 and thereafter

To be attached to and made a part of your Blue Cross and Blue Shield of Texas individual health insurance Contract

Your Contract is amended as follows:

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

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

- a. A group health plan that is a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
- b. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
  - (1) group health insurance coverage;
  - (2) individual health insurance coverage; and
  - (3) short-term, limited-duration insurance;
- c. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
- d. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
- e. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services, and for their dependents);
- f. A medical care program of the Indian Health Service or of a tribal organization;
- g. A State health benefits risk pool;
- h. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
- i. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
- j. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)); or
- k. Title XXI of the Social Security Act (State Children's Health Insurance Program.)

***Creditable Coverage does not include:***

- a. Coverage only for accident (including accidental death and dismemberment);
- b. Disability income coverage;
- c. Liability insurance, including general liability insurance and automobile liability insurance;
- d. Coverage issued as a supplement to liability insurance;
- e. Workers' compensation or similar coverage;

- f. Automobile medical payment insurance;
- g. Credit-only insurance (for example, mortgage insurance);
- h. Coverage for onsite medical clinics;
- i. Limited scope dental benefits, visions benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance;
- j. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
- k. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
- l. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);
- m. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and
- n. Similar supplemental coverage provided to coverage under a group health plan.

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

Blue Cross and Blue Shield of Texas

By: Patricia Hemingway Hall  
President

Date: \_\_\_\_\_

## An Amendment

Effective January 1, 1998

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

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

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

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

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

c. Adding the following new definitions:

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

1. A self-funded or self-insured employee welfare benefit plan that provides health benefits and is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); or
2. Any group or individual health benefit plan provided by a health insurance carrier or health maintenance organization; or
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare); or
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928; or
5. Chapter 55 of Title 10, United States Code; or
6. A medical care program of the Indian Health Service or of a tribal organization; or
7. A state health benefits risk pool; or
8. A plan offered under Chapter 89 of Title 5, United States Code; or
9. A public health plan as defined by federal regulations; or
10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C., Section 2504(e)).

***Creditable Coverage does not include:***

1. Accident only, disability income insurance, or a combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' Compensation or similar insurance;
5. Credit-only insurance;

6. Coverage for onsite medical clinics;
7. Coverage for limited-scope dental or vision benefits;
8. Long-term care, nursing home care, home health care, or community-based care coverage or benefits, or any combination thereof;
9. Coverage for a specified disease or illness;
10. Hospital indemnity or other fixed indemnity insurance; or
11. Medicare supplemental health insurance, supplemental to the group coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et. seq.), and similar supplemental coverage provided under a group plan; and
12. Other similar coverage specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

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

1. Diabetic Equipment
  - a. Blood glucose monitors, including monitors for the blind
  - b. Insulin pumps and necessary accessories,
  - c. Insulin infusion devices, and
  - d. Podiatric appliances for the prevention of complications associated with diabetes.
2. Diabetic Supplies
  - a. Test strips for blood glucose monitors,
  - b. Visual reading and urine test strips,
  - c. Lancets and lancet devices,
  - d. Insulin and insulin analogs,
  - e. Injection aids,
  - f. Syringes,
  - g. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels, and
  - h. Glucagon emergency kits.

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

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

**Health Status Related Factor** means:

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



5. Medical history;
  6. Genetic information;
  7. Evidence of insurability, including conditions arising out of acts of family violence; and
  8. Disability.
2. The **Benefits Provided** section of Your Contract is amended by deleting the wording of **Hospital Admissions** in its entirety and substituting the following:

#### **Hospital Admissions**

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

- a. If the Maternity Care Option was selected,
  - (1) 48 hours following an uncomplicated vaginal delivery; and
  - (2) 96 hours following an uncomplicated delivery by caesarean section.
- b. Treatment of Breast Cancer,
  - (1) 48 hours following a mastectomy, and
  - (2) 24 hours following a lymph node dissection.

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

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

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

#### ***Benefits for Well-Child Care***

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

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

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

*Benefits for Childhood Immunizations*

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

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

Allergy injections are not considered immunizations under this benefit provision.

*Benefits for Certain Tests for the Detection of Prostate Cancer*

If a male Participant incurs *Medical-Surgical Expense* for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be determined on the same basis as for any other sickness. Benefits will only be provided for:

- (1) A physical examination for the detection of prostate cancer; and
- (2) A prostate-specific antigen test used for the detection of prostate cancer for each male Participant under this Contract who is at least:
  - (a) 50 years of age and asymptomatic; or
  - (b) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

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

Any services or supplies provided in connection with a routine physical examination (including a routine Pap smear), diagnostic screening, or immunizations. This exclusion does not apply to:

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

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

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

1. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant while covered under this Contract; or
2. Treatment provided for reconstructive surgery following cancer surgery while the Participant is covered under this Contract; or
3. Surgery performed on a newborn child for the treatment or correction of a congenital defect; or
4. Surgery performed on a Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast.
5. Surgical reconstruction of a breast on which mastectomy surgery has:
  - (a) Been performed; and
  - (b) Not been performed.

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

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

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

1. Who was continuously covered for an aggregate of 18 months under Creditable Coverage if the previous coverage was in effect up to a date not more than 63 days before the Effective Date of the Participant's coverage under this Contract, excluding any waiting periods; and
2. Whose most recent Creditable Coverage was under a group health plan, governmental plan or church plan.

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

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

### **Article VI — Termination of Coverage**

- A. The coverage of the Subscriber and all covered Dependents under this Contract will terminate on the earliest of the following dates:
1. On the last day of the last period for which the premium for this Contract has been paid to the Carrier, subject to the grace period provided in Article VII, Section C; or
  2. On the last day of any Contract Month upon written request for termination of Your Contract made by the Subscriber and received by the Carrier prior thereto; or

3. On the Contract Date for fraudulent or intentional misrepresentation of a material fact; or
  4. On the date of death of the Subscriber; or
  5. On the last day of any Contract Month in which a Subscriber no longer resides, lives, or works in an area for which We are authorized to provide coverage, but only if coverage is not renewed or not continued uniformly without regard to any Health Status Related Factor of covered individuals; or
  6. On date following 90 days advance notice by the Carrier to the Subscriber, but only if it is terminating all other contracts of this class; provided that the Carrier offers any hospital, medical or surgical insurance coverage on a guaranteed basis to all applicants at the time of discontinuance of Your Contract.
  7. In the event this Contract is terminated in accordance with the provisions of Subsection 6, above, a Participant does not elect to purchase another individual hospital, medical or surgical insurance policy:
    - a. Coverage for any continuous illness (except for pregnancy) or injury of a Participant which commenced while this Contract was in force shall, at termination, continue during the continuous Total Disability of the Participant to:
      - (1) The duration of the policy benefit period,
      - (2) Payment of maximum benefits under this Contract, or
      - (3) To a period of not less than 90 days.

“Total Disability,” for purposes of this Subsection 7, means the complete inability of a Participant as a result of injury or sickness to perform the usual tasks of his occupation, provided such Participant is not otherwise gainfully employed for wage or profit and is under the regular care of a Physician or Professional Other Provider.
    - b. Coverage for pregnancy which commenced while this Contract was in force and for which benefits would have been available, shall at termination, continue to the end of such pregnancy.
  8. The Carrier may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if the Carrier:
    - a. Notifies the Texas Department of Insurance Commissioner not later than 180 days prior to the date coverage under the first individual hospital, medical or surgical health insurance plan terminates;
    - b. Notifies each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and
    - c. Act uniformly without regard to any Health Status Related Factor of covered individuals who may become eligible for coverage.
- B. In addition to the provisions of Section A, above, the coverage of any Dependent under this Contract shall terminate on the earliest of the following dates:
1. At the end of Your Contract Month in which the Dependent ceases to be a Dependent as defined in Article I, Section K, of Your Contract, provided that if such date falls within a period for which premium has been accepted by the Carrier, coverage shall not terminate until the last day of such period; or
  2. On the date of death of the Dependent; or
  3. On the last day of any Contract Month on written request for termination of the Dependent's coverage made by the Subscriber and received by the Carrier prior thereto; or

4. On the last day of any Contract Month in which a Dependent no longer resides, lives, or works in an area for which We are authorized to provide coverage, but only if coverage is not renewed or not continued uniformly without regard to any Health Status Related Factor of covered individuals.
- C. Notwithstanding the provisions of Section A, above, within 30 days of the death of the Subscriber, all remaining eligible Dependents may jointly elect in written notice to the Carrier to continue this Contract with the eldest Dependent as Subscriber.
- D. Notwithstanding the provisions of Section B, above, within 30 days of a divorce, marriage of a child, or a child attaining age 23, the former Dependent losing coverage may elect to apply for coverage in his own name.

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

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

**Effective January 1, 2000**

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

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

2. The **Definitions** section of Your Contract is amended in the definition of **Other Provider** by:
  - a. Adding the following to **Professional Other Provider**:
    - Licensed Acupuncturist
  - b. Changing the name of **Licensed Hearing Aid Fitter and Dispenser** to **Licensed Hearing Instrument Fitter and Dispenser**.
3. The **Benefits Provided** section of Your Contract is amended as follows:
  - a. The section entitled **Benefits for Cosmetic, Reconstructive, or Plastic Surgery** is amended by deleting the subsection (e) in its entirety and substituting the following:
    - (e) Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

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

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

- c. The subsection entitled **Benefits for Childhood Immunizations** is changed to **Required Benefits for Childhood Immunizations**.
- d. By adding the following new benefit provisions:

***Required Benefits for Screening Test for Hearing Impairment***

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

- For a screening test for hearing loss from birth through the date the child is 30 days old; and
- Necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

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

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

***Benefits for Treatment of Diabetes***

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetic Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following:

a. **Diabetic Equipment**

- (1) Blood glucose monitors (including noninvasive glucose monitors and monitors designed to be used by the blind);
- (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:
  - Batteries
  - Skin preparation items,
  - Adhesive supplies,
  - Infusion sets,
  - Insulin cartridges,
  - Durable and disposable devices to assist in the injection of insulin, and
  - Other required disposable supplies;
- (3) Insulin infusion devices; and
- (4) Podiatric appliances, including up to two pairs of therapeutic footwear per Benefit Period, for the prevention of complications associated with diabetes.

b. **Diabetic Supplies**

- (1) Test strips for blood glucose monitors,
- (2) Visual reading and urine test strips and tablets for glucose, ketones and protein,

- (3) Lancets and lancet devices,
- (4) Insulin and insulin analogs preparations,
- (5) Injection aids, including devices used to assist with insulin injection and needleless systems,
- (6) Biohazard disposable containers,
- (7) Insulin syringes,
- (8) Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- (9) Glucagon emergency kits.

However, insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, for controlling blood sugar levels, including prescription medications which are required by law to be labeled "Caution: Federal Law prohibits dispensing without a prescription", will be covered under the Prescription Drug Program.

- c. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
- d. New and improved treatment and monitoring equipment or supplies which are approved by the U. S. Food and Drug Administration if it is determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider.
- e. Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetic Supplies* (for which a Physician or Professional Other Provider has written an order) and *Diabetic Management Services/Diabetes Self-Management Training*. Such items, when obtained for a *Qualified Participant*, shall include but not be limited to the following initial and follow-up instruction concerning:
  - (1) The physical cause and process of diabetes;
  - (2) Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
  - (3) Prevention and treatment of special health problems for the diabetic patient;
  - (4) Adjustment to lifestyle modifications; and
  - (5) Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

*Diabetes Self-Management Training* for the *Qualified Participant* will include the development of an individualized management plan that is created for and in collaboration with the *Qualified Participant* (and/or his or family or caretaker) to understand the care and management of diabetes, including nutritional counseling and proper use of *Diabetes Equipment* and *Diabetes Supplies*.

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



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

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

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

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

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

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

Any Speech and Hearing Services. This exclusion does not apply to the following except as provided in the Special Benefit Provisions section of Article IV, Section 1, of Your Contract:

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

Effective January 1, 2002

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

**Dependent** means:

- a. A Subscriber's spouse; or
- b. Any unmarried child who is under 25 years of age.

**Child** means:

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

4. A child for whom the Subscriber has received a court order or an order requiring that Participant have financial responsibility for providing health insurance; or
  5. A grandchild of the Subscriber who is dependent upon the Subscriber for federal income tax purposes at the time application for coverage is made.
2. The **Definitions** section of Your Contract is amended by adding the following new subsections to the definition of **Medical-Surgical Expense**.

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

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

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

- a. **Facility Other Provider** — an institution or entity, only as listed:
  1. Durable Medical Equipment Provider
  2. Home Infusion Therapy Provider
  3. Imaging Center
  4. Independent Laboratory
  5. Prosthetic/Orthotics Provider
  6. Renal Dialysis Center
  7. Therapeutic Center
- b. **Professional Other Provider** — a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
  1. Advanced Practice Nurse
  2. Doctor of Chiropractic
  3. Doctor of Dentistry
  4. Doctor of Optometry
  5. Doctor of Podiatry
  6. Doctor in Psychology
  7. Licensed Acupuncturist
  8. Licensed Audiologist
  9. Licensed Chemical Dependency Counselor
  10. Licensed Clinical Social Worker
  11. Licensed Dietitian
  12. Licensed Hearing Instrument Fitter and Dispenser
  13. Licensed Physical Therapist
  14. Licensed Professional Counselor
  15. Licensed Occupational Therapist
  16. Licensed Speech-Language Pathologist
  17. Marriage and Family Therapist
  18. Nurse First Assistant
  19. Physician Assistant
  20. Psychological Associate who practices solely under a Licensed Psychologist
  21. Surgical Assistant

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

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

**Acquired Brain Injury** means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

**Outpatient Contraceptive Services** means a consultation, examination, procedure or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

**Telehealth Service** means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- a. Compressed digital interactive video, audio, or data transmission;
- b. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- c. Other technology that facilitates access to health care services or medical specialty expertise.

**Telemedicine Medical Service** means a health care service initiated by a Physician or provided by a health professional acting under Physician delegation and supervision for purposes of patient assessment by a health professional, diagnosis or consultation by a Physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

- a. Compressed digital interactive video, audio or data transmission;
- b. Clinical data transmission using computer imaging by way of still-image capture; and
- c. Other technology that facilitates access to health care services or medical specialty expertise.

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

***Benefits for Treatment of Acquired Brain Injury***

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

- Cognitive rehabilitation therapy — Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
- Cognitive communication therapy — Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
- Neurocognitive therapy and rehabilitation services — (1) Therapy designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities and (2) Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- Neurobehavioral treatment — Interventions that focus on behavior and the variables that control behavior.
- Neurobehavioral testing — An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

- Neuro-physiological testing — An evaluation of the functions of the nervous system.
- Neuropsychological testing — The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- Neuro-psychological treatment — Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- Neuro-physiological treatment — Interventions that focus on the functions of the nervous system.
- Psychophysiological testing — An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- Psychophysiological treatment — Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- Neurofeedback therapy — Services that utilizes operant conditioning learning procedure based on electroencephalographs (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- Remediation — The process(es) of restoring or improving a specific function.
- Post-acute transition services — Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- Community reintegration services — Services that facilitate the continuum of care as an affected individual transitions into the community.

*Services* means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

*Therapy* means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

#### *Benefits for Certain Tests for Detection of Colorectal Cancer*

If a Participant 50 years of age or older and who is at normal risk for developing colon rectal cancer incurs *Medical-Surgical Expense* for a diagnostic medically recognized screening examination for the detection of colorectal cancer, benefits will be determined on the same basis as for any other sickness for a:

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

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

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

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

5. Newborn Screening Tests for Hearing Impairment, or
6. Certain Tests for the Detection of Colorectal Cancer.
7. The **Termination of Coverage** section of Your Contract is amended by deleting the wording of Section 2a in its entirety and substituting the following:
  - a. At the end of Your Contract Month in which the Dependent ceases to be a Dependent under this Contract as defined in Article I of Your Contract as amended, provided that:
    - If such date falls within a period for which the Carrier has accepted premium, coverage shall not terminate until the last day of such period; or
    - Coverage for any unmarried child who is medically certified as Disabled and dependent upon you shall not terminate upon reaching age 25 if the child continues to be both (a) disabled and (b) dependent upon You for more than one-half of his support as defined by the *Internal Revenue Code* of the United States.

*Disabled* means any medically determinable physical or mental condition that prevents the child from engaging in self-sustaining employment. The disability must begin while the child is covered under this Contract and before the child attains age 25. You must submit proof of the disability and dependency to Us within 31 days following the child's attainment of age 25. As a condition to the continued coverage of a child as a disabled Dependent beyond age 25, We may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of age 25.
8. The **Termination of Coverage** section of Your Contract is amended by deleting the wording of section 4 in its entirety and substituting the following:
  4. Notwithstanding the provision of Section 2, above, within 30 days of a divorce, marriage of a child or attaining age 25, the former Dependent losing coverage may elect to apply for coverage in his own name.

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

In the case of a change in marital status, the new Contract will have the same Effective Date as the Contract under which coverage was afforded prior to the loss of coverage. The rights provided under this Section 4 shall terminate if We do not receive the application within the 30-day period.
9. The **Termination of Coverage** section of Your Contract is amended by deleting item b of the wording in the subsection regarding "Disclosure Authorization" in its entirety and substituting the following:
  - b. As a condition to the continued coverage of a child as a disabled Dependent beyond the age of 25, We shall have the right to require periodic certification of the child's physical or mental condition and dependency, but not more frequently than annually after the two-year period following the child's attainment of age 25.

1. The **Definitions** section of Your Contract is amended in the term "Other Provider" by deleting the term "Licensed Master Advanced-Clinical Social Worker" and substituting "Licensed Clinical Social Worker."
2. The **Benefits Provided** section of Your Contract is amended by adding the following new benefit provision:

***Certain Therapies for Children with Development Delays***

*Medical-Surgical Expense* benefits are provided for a Dependent child under three years of age with *developmental delays* for the necessary rehabilitative and habilitative therapies in accordance with an *individualized family service plan* issued by the Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas *Human Resources Code*. Such therapies include:

- Occupational therapy evaluation and services;
- Physical therapy evaluations and services;
- Speech therapy evaluations and services; and
- Dietary or nutritional evaluations.

The *individualized family service plan* must be submitted to Us prior to the commencement of services, and when the *individualized family service plan* is altered.

*Developmental delays* means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

- Cognitive development;
- Physical development;
- Communication development;
- Social or emotional development; or
- Adaptive development.

*Individualized family service plan* means an initial and ongoing treatment plan developed by the Texas Interagency Council on Early Childhood Intervention.

After the age of three, when services under the *individualized family service plan* are completed, Eligible Expenses, as otherwise coverage under this Contract, will be available. All contractual provision of Your Contract will apply, including but not limited to defined terms, limitations and exclusions, preexisting conditions, and benefit maximums.

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

Any services or supplies provided for Dietary and Nutritional Services, except as may be provided in this Contract for:

1. An inpatient nutritional assessment program provided in and by a Hospital and approved by Us;
2. Treatment of Diabetes; and

3. Dietary or nutritional evaluations provided in conjunction with Certain Therapies for Children with Developmental Delays.
4. The **Limitations and Exclusions** section of Your Contract is amended by deleting the wording of the exclusion regarding "routine physical exam" in its entirety and substituting the following:

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

1. Mammography Screening;
  2. Well Child Care,
  3. Childhood Immunizations;
  4. Certain Tests for the Detection of Prostate Cancer,
  5. Newborn Screening Tests for Hearing Impairment;
  6. Certain Tests for the Detection of Colorectal Cancer; and
  7. Certain Therapies for Children with Developmental Delays.
5. The **Limitations and Exclusions** section of Your Contract is amended by deleting the wording of the exclusion regarding "Medical Social Services" in its entirety and substituting the following:

Except as specifically included as an Eligible Expense, any Medical Social Services; any outpatient family counseling and/or therapy bereavement counseling, vocational counseling, Marriage and Family Therapy and/or counseling; any services provided by a Licensed Clinical Social Worker, a Licensed Professional Counselor, or a Marriage and Family Therapist.

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

Any Speech and Hearing Services. This exclusion does not apply to the following except as provided in the Special Benefit Provisions section of Article IV, Section 1, of Your Contract:

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

**Effective January 1, 2006**

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

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

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

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

*Creditable Coverage does not include:*

- a. Coverage only for accident (including accidental death and dismemberment);
- b. Disability income coverage;
- c. Liability insurance, including general liability insurance and automobile liability insurance;
- d. Coverage issued as a supplement to liability insurance;
- e. Workers' compensation or similar coverage;
- f. Automobile medical payment insurance;
- g. Credit-only insurance (for example, mortgage insurance);
- h. Coverage for onsite medical clinics;
- i. Limited scope dental benefits, visions benefits, or long-term care benefits if they are provided under a separate policy, certificate, or contract of insurance;
- j. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
- k. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
- l. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);
- m. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code* (also known as TRICARE supplemental programs); and
- n. Similar supplemental coverage provided to coverage under a group health plan.



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

*Benefits for Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer*

If a female Participant 18 years of age or older incurs Medical-Surgical Expense for an annual medically recognized diagnostic examination for the early detection of cervical cancer, benefits provided under this Contract shall include:

- A conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of human Papillomavirus.
- Such screening test must be performed in accordance with the guidelines adopted by:
  - (a) The American College of obstetricians and Gynecologists; or
  - (b) Another similar national organization of medical professionals.

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

Any services or supplies provided in connection with a routine physical examination, diagnostic screening, or immunizations. This exclusion does not apply to the following except as may be provided for in the Special Benefit Provisions section in Article IV, of Your Contract:

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

**Effective September 1, 2006**

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1. The **Definitions** section of Your Contract is amended by deleting the definition of **Health Status Related Factor** and adding the following new definition:

**Health Status Related Factor** means:

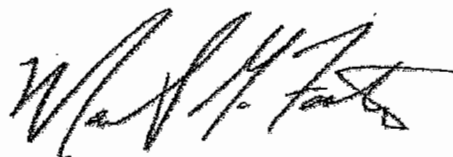
1. Health status;
2. Medical condition, including both physical and mental illness;
3. Claims experience;
4. Receipt of health care;
5. Medical history;
6. Genetic information;
7. Evidence of insurability; and
8. Disability.

2. The **Payment Of Benefits; Participant/Provider Relationship** section of Your Contract is amended by deleting the last item of the **Payment of Benefits** subsection and replacing it with the following new item:

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

3. The **Standard Provisions** section of Your Contract is amended by adding the following provision:

**Time of Payment of Claims:** Benefits payable under this policy for any loss will be paid immediately upon receipt of due written proof of such loss.



President of Blue Cross Blue Shield of Texas

## An Amendment

**Effective Date January 1, 2008**

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

Article IV of this Contract, as previously amended, is amended by deleting the section entitled *Benefits for Acquired Brain Injury* in its entirety and substituting the following:

### ***Benefits for Treatment of Acquired Brain Injury***

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

- Cognitive rehabilitation therapy — Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
- Cognitive communication therapy — Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
- Neurocognitive therapy and rehabilitation services — (1) Therapy designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities and (2) Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- Neurobehavioral treatment — Interventions that focus on behavior and the variables that control behavior.
- Neurobehavioral testing — An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
- Neuro-physiological testing — An evaluation of the functions of the nervous system.
- Neuropsychological testing — The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- Neuro-psychological treatment — Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- Neuro-physiological treatment — Interventions that focus on the functions of the nervous system.
- Psychophysiological testing — An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- Psychophysiological treatment — interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- Neurofeedback therapy — Services that utilizes operant conditioning learning procedure based on electroencephalographs (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

- Remediation — The process(es) of restoring or improving a specific function.
- Post-acute transition services — Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration, including outpatient day treatment or other post-acute care treatment. This shall include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under this plan who:
  - has incurred an Acquired Brain Injury;
  - has been unresponsive to treatment; and
  - becomes responsive to treatment at a later date.
- Community reintegration services — Services that facilitate the continuum of care as an affected individual transitions into the community, including outpatient day treatment or other post-acute care treatment.

**Services** means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

**Therapy** means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury.

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

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

Any services or supplies for Eligible Expenses incurred for a Preexisting Condition during a period of 24 months beginning with the Participant’s Effective Date under this Contract. This Preexisting Condition exclusion shall not apply to a Participant who was continuously covered for an aggregate of 18 months under Creditable Coverage if the previous coverage was in effect up to a date not more than 63 days before the Effective Date of the Participant’s coverage under this Contract, excluding any waiting periods.

If a Participant does not have aggregate Creditable Coverage totaling 18 months, BCBSTX will credit the time the Participant was previously covered under Creditable Coverage if the previous coverage was in effect at any time during the 18 months preceding (a) the first day coverage is effective under this Contract, if there is not a waiting period; or (b) the day the applicant files a substantially complete application for coverage, if there is a waiting period.



President of Blue Cross and Blue Shield of Texas

## An Amendment

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

*Your Contract is amended as follows:*

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

### **Use of Non-Contracting Providers**

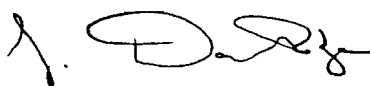
- When you choose to receive services, supplies, or care from *Hospitals and Facility Other Providers* not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount) no payment will be made by us.
  - When you choose to receive services, supplies, or care from a *Physicians, and Professional Other Providers Provider* that does not contract with BCBSTX (a non-contracting Provider), you receive benefits for covered services that will be reimbursed based on the BCBSTX non-contracting Allowable Amount, which in most cases is less than the Allowable Amount applicable for BCBSTX contracted Physicians, and Professional Other Providers. Please see the definition of non-contracting Allowable Amount in the **DEFINITIONS** section of this Benefit Booklet. **The non-contracted Provider is not required to accept the BCBSTX non-contracting Allowable Amount as payment in full and may balance bill you for the difference between the BCBSTX non-contracting Allowable Amount and the non-contracting Provider's billed charges. You will be responsible for this balance bill amount, which may be considerable.** You will also be responsible for charges for services, supplies and procedures limited or not covered under the Plan and any applicable Deductibles, Coinsurance Amounts, and Copayment Amounts.
2. The **Definitions** section of Your Contract is amended by deleting the definition of Allowable Amount in its entirety and replacing it with the following:

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

- *For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan* – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.
- *For Hospitals and Facility Other Providers not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount)* – no payment will be made by us.

- ***For Physicians, and Professional Other Providers not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount)*** – The Allowable Amount will be the lesser of the Physicians or Professional Other Provider's billed charges or the BCBSTX non-contracting Allowable Amount. The non-contracting Allowable Amount is developed using BCBSTX Allowable Amount data for similar Physicians or Professional Other Providers at a service level identified by standard contracting identification methods. The Allowable Amount for non-contracting Physicians or Professional Other Providers represents the average contract rate for Physicians or Professional Other Providers contracting with us adjusted by a predetermined factor established by BCBSTX and updated on a periodic basis. Such factor shall not be less than 75 % and will be updated not less frequently than once every two years. The non-contracting Allowable Amount does not equate to the Physicians or Professional Other Provider's billed charges and Participants receiving services from a non-contracting Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracting Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back your BCBSTX Identification Card.
- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the *same* day will be the amount for the single procedure with the highest Allowable Amount *plus* a determined percentage of the Allowable Amount *for each* of the other covered procedures performed.
- ***For drugs administered by a Home Infusion Therapy Provider*** – The Allowable Amount will be the lesser of (1) the actual charge, or (2) the Average Wholesale Price (AWP) plus a predetermined percentage mark-up or mark down from the AWP wholesale price established by BCBSTX and updated on a periodic basis.

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



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

## An Amendment

**Effective Date January 1, 2010**

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

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

By adding the following new definitions:

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

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

Routine patient care costs do not include:

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

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

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

- (1) Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- (2) Severe food protein-induced enterocolitis syndromes;
- (3) Eosinophilic disorders, as evidenced by the results of biopsy; and
- (4) Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

A Prescription Order from your Health Care Practitioner is required.

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

1. By adding the following new sections:

***Benefits for Routine Patient Costs for Participants in Certain Clinical Trials***

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

## An Amendment

**Effective Date January 1, 2010**

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

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

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

### ***Benefits for Early Detection Tests for Cardiovascular Disease***

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

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

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

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

**2.** By deleting the Section **Precertification Requirements** in its entirety and replacing it with the following:

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

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

### **(1) Hospital Admissions**

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



## An Amendment

**Effective Date January 1, 2010**

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

When a Hospital Admission is precertified, a length-of-stay is assigned. This Contract is required to provide a minimum length of stay in a Hospital for treatment of breast cancer of:

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

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

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

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

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

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

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

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

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

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

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

## An Amendment

**Effective Date January 1, 2010**

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

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

### **(3) Organ and Tissue Transplants**

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

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

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

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

The General Provisions Section of Your Contract is amended By deleting the Section **Review of Claim Determinations** in its entirety and replacing it with the following:

#### **Review of Claim Determinations:**

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

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

## An Amendment

**Effective Date January 1, 2010**

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

additional information is requested, it must be furnished before processing of the claim can be completed.

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

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

- (1) Submit a written request for review mailed to Us at Our Administrative Office in Richardson, Dallas County, Texas. The request must state the Participant's full name and Subscriber identification number and the charges on the claim he wants reviewed.
- (2) Include in the written request the items of concern regarding Our determination and all additional information (including medical information) that the Participant believes has a bearing on why the determination was incorrect.

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



President of Blue Cross and Blue Shield of Texas

**Notice of Ten-Day Right to Examine Contract**

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