PPO Select Choice Series III
Individual Coverage

Table *of Contents*

BlueCross BlueShield
of Texas

HIPAA NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

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

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

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

Uses and Disclosures of Protected Health Information

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

information exchange, a reinsurer, or to our attorneys.

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

Individual Rights

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

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

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

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

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

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

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

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

Questions and Complaints

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

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

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

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

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

Preauthorization | *Information*

About Preauthorization

Your Select® Choice plan requires preauthorization for all inpatient hospital admissions, extended hospital stays, extended care expenses, home infusion therapy, and organ and tissue transplants. Preauthorization helps ensure that your hospital stay is medically necessary and protects you from unnecessary procedures.

How to Preauthorize

To preauthorize, you, your physician, the hospital or family member must call the toll-free number listed on the back of your ID card. A nurse will work with the caller to complete the preauthorization process. It can usually be taken care of with just one phone call.

Points to Remember

You are responsible for preauthorization. Failure to preauthorize your care before it is administered results in:

- A $250 penalty for in-hospital stays
- A 50% penalty (up to $500) for extended care and home infusion therapy services
- Your claim may be denied if it is determined to be medically unnecessary

In an Emergency

When a medical emergency occurs, there is seldom time to preauthorize a hospital admission. Be sure to have someone call to authorize your stay within two days after you are admitted. Preauthorization calls made after business hours are recorded and returned the next business day.

To preauthorize,
call toll free:
(800) 441-9188

(972) 783-4475
in Dallas

8 a.m. to 8 p.m. CT
Monday through Friday

Privacy | *Notice*

Confidentiality And Security

Blue Cross and Blue Shield of Texas has 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 applications, claims 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 of Texas.

Independent Insurance Agents

The independent insurance agents authorized to sell Blue Cross and Blue Shield of Texas products and the products of our affiliates are not employees. 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. However, as a business associate of Blue Cross and Blue Shield of Texas, your agent is subject to the same privacy laws that govern us.

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.

Information | *We May Disclose*

Blue Cross and Blue Shield of Texas regards all personal information as confidential. We will not disclose your personal information unless we are allowed or required by law to make the disclosure, or if you tell us we can. These disclosures are generally made to our affiliates, administrators, consultants, and regulatory or governmental authorities. We may also disclose information as necessary to administer your health plan, pay claims and, as necessary, effect transactions in the ordinary course of our business. Our affiliates are subject to the same policies regarding privacy of our information as we are.

Blue Cross and Blue Shield of Texas sometimes works with outside firms to help with services and marketing. As permitted by law, these firms may use certain identifying and non-medical information. It is our policy to require outside firms to make a written pledge to maintain the confidentiality of the personal information and abide by all applicable privacy laws. These firms are prohibited from using or disclosing personal information for any purpose other than the work they are performing, or as required by law.

Important Notice to Persons on Medicare — This Insurance Duplicates some Medicare Benefits

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays the benefits stated in the policy and coverage for the same event is provided by Medicare. Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. Medicare generally pays for most or all of these expenses:

- Hospitalization
- Physician services
- Hospice
- Other approved items and services

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

Before you buy this insurance
For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

NOTICE

This Policy is subject to: (1) the right to adjust the premium on renewal upon 60 days notice to You and as otherwise allowed or specified in Article VII. Such adjustments in rates shall become effective on the date specified in said notice; (2) guaranteed renewability and termination of coverage in accordance with Article VII, and (3) preauthorization requirements.

NOTICE OF TEN-DAY RIGHT TO EXAMINE POLICY

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

Blue Cross and Blue Shield of Texas

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

Has issued this Guaranteed Renewable individual

PREFERRED PROVIDER POLICY

providing

Comprehensive Major Medical Expense Coverage

to

The Subscriber named on the Identification Card provided for this Policy.

This Policy is effective from 12:01 a.m. on the Effective Date shown on the Identification Card and Schedule of Coverage and will be continued in effect by the payment of premiums at the rates determined by Us in accordance with the provisions in the **Premiums** section until terminated as provided in the **Termination of Coverage** provision.

In Consideration of the Subscriber's receipt and signed acceptance of any required Amendatory Endorsement and/or Coverage Exclusion Rider, and payment of premiums in accordance with the provisions hereof, We agree to provide benefits to the Subscriber under the terms of this Policy as recited on this and the following pages from the Effective Date of this Policy and for consecutive premium payment periods thereafter, unless this Policy is terminated as provided in Article VII.

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

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

Jeffrey R Tikkanen
President, Retail Markets
Blue Cross and Blue Shield of Texas

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

Table of Contents

IMPORTANT NOTICE

To obtain information or make a complaint:

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

  1-888-697-0683

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

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

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

  1-800-252-3439

- You may write the Texas Department of Insurance at:

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

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

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

  1-888-697-0683

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

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

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

  1-800-252-3439

- Puede escribir al Departmento de Seguros de Texas:

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

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

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

Article I - Definitions

As used in this Policy:

Accidental Injury means an accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

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

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

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

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

  Notwithstanding the preceding sentence, the non-contracting Allowable Amount for Home Health Care is developed from base Medicare national per visit amounts for low utilization payment adjustment, or LUPA, episodes by Home Health discipline type adjusted for duration and adjusted by a predetermined factor established by Us. Such factor shall be not less than 75% and shall be updated on a periodic basis.

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

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

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

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

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

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

Brand Name Drug means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic Drug to Preferred Brand Name Drug due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would also result in a corresponding change in Copayment Amount obligations from Generic Drug to Preferred Brand Name Drug.
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Calendar Year means the period commencing on a January 1 and ending on the next succeeding December 31.

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

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

a. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells); or
b. Urine auto injection (injecting one's own urine into the tissue of the body); or
c. Skin irritation by Rinkel method; or
d. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or
e. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Coinsurance Amount means the dollar amount expressed as a percentage of Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

Complications of Pregnancy means:

a. Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including, but not limited to, acute 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, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.
b. Termination of pregnancy by non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Compound Drugs means those drugs which are non-commercially available compounded medications regardless of whether or not one or more ingredients in the compound requires a Prescription Order. (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)

Copayment Amount means the amount required for most office visits and consultation charges only. If the services provided require a return visit on a different day, a new Copayment Amount will be required for any office visits and/or consultation charge. Eligible Expenses for other covered charges provided at the time of the office visit or consultation (e.g. lab or X-ray) will be subject to the Deductible and Coinsurance Amount. In the case of **Your Pharmacy Benefits**, Copayment Amount means the fixed dollar amount paid by You for each Prescription Order dispensed or refilled at a Participating Pharmacy.

Cosmetic, Reconstructive or Plastic Surgery means surgery that:

a. Can be expected or is intended to improve Your physical appearance; or
b. Is performed for psychological purposes; or
c. Restores form but does not correct or materially restore a bodily function.

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

a. Which is Medically Necessary and is ordered by a Health Care Practitioner naming You as the recipient;
b. For which a written or verbal Prescription Order is prepared by a Health Care Practitioner;
c. For which a separate charge is customarily made;
d. Which is not entirely consumed at the time and place that the Prescription Order is written;
e. For which the U.S. Food and Drug Administration (FDA) has given approval for at least one indication; and
f. Which is dispensed by a Pharmacy and is received by You while covered under this Policy, **except when** received from a Health Care Practitioner's office, or during confinement while a patient in a Hospital or other acute care institution or facility.

Creditable Coverage means coverage under any one of the following:

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

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

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

Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to You 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 You walk, bathe, dress, eat, prepare special diets, and take medication.
INDTXDF200

Deductible means the dollar amount of Eligible Expenses that You must incur before benefits under this Policy will be available.

Dependent means:

a. A Subscriber's spouse; or
b. Any *child* who is under 26 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 is the legal guardian;

regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors.

A *child* also includes an unmarried grandchild of the Subscriber who is dependent upon the Subscriber for Federal income tax purposes at the time application for coverage is made.

Dietary and Nutritional Services means Your education, counseling, or training (including printed material) regarding:

a. Diet;
b. Regulation or management of diet; or
c. The assessment or management of nutrition.

Durable Medical Equipment means equipment and supplies ordered by a Provider for everyday or extended use. Coverage for Durable Medical Equipment may include: oxygen equipment, wheelchairs, crutches. 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 *non-covered* equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment.
INDTXDF300

Effective Date means the date Your coverage becomes effective under this Policy.

Eligible Expenses means either *Inpatient Hospital Expense*, *Medical-Surgical Expense*, *Extended Care Expense Special Benefit Provisions*, or *Your Pharmacy Benefits*, all as specified in this Policy.

Emergency means a medical condition of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, Sickness, or injury is of such a nature that failure to get immediate medical care could result in:

a. Placing the patient's health in serious jeopardy;
b. Serious impairment to bodily functions,
c. Serious dysfunction of any bodily organ or part,
d. Serious disfigurement, or
e. In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Room Care means Emergency Services received in an emergency room.

Emergency Services means health care services provided in a Hospital emergency facility, freestanding emergency medical care facility or comparable facility to evaluate and stabilize an Emergency.

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

a. Controlled environment; or
b. Sanitizing the surroundings, removal of toxic materials; or
c. Use of special non-organic, non-repetitive diet techniques.

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

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

a. Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
b. Are appropriate for the Hospital or Facility Other Provider in which they were performed; and
c. The Health Care Practitioner, Physician or Professional Other Provider has had the appropriate training and experience to provide the treatment or procedure.

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

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

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

Generic Drug means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding Participant Copayment Amount or Coinsurance Amount responsibility, BCBSTX utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information.
INDTXDF401

Health Care Practitioner means an advanced practice nurse, doctor of medicine, doctor of dentistry, physician assistant, doctor of osteopathy, doctor of podiatry, or other licensed person with prescription authority.

Health Status Related Factor means:

a. Health status;
b. Medical condition, including both physical and mental illness;
c. Claims experience;
d. Receipt of health care;
e. Medical history;
f. Genetic information;
g. Evidence of insurability including conditions arising out of acts of family violence, and
h. Disability.

Home Health Agency means a business that provides Home Health Care and is licensed by the Texas Department of Human Services under Chapter 142, Health and Safety Code or its successor. 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 .

Home Health Care means the health care services for which benefits are provided under this Policy 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.

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

a. Drugs and IV solutions;
b. Pharmacy compounding and dispensing services;
c. All equipment and ancillary supplies necessitated by the defined therapy;
d. Delivery services;
e. Patient and family education;
f. Nursing services.

Over-the-counter products which do not require a Health Care Practitioner prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

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

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

a. Licensed in accordance with state law (where the state law provides for such licensing); or
b. Certified by Medicare as a supplier of Hospice Services.

Hospice Services means services for which benefits are provided under this Policy 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.

Hospital means an acute care facility which:

a. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is operated pursuant to the law;
b. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from its patients;
c. Maintains and operates a minimum of five beds;
d. Has organized departments of medicine, diagnostic, x-ray and laboratory facilities, major surgery (either on its premises or in facilities available to the Hospital on a contractual prearranged basis); and maintains permanent medical history records on all patients;
e. Provides 24-hour nursing services by or under the supervision of a registered nurse; and
f. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, custodial care home, health resort, spa or sanitarium, place for rest, place for the aged, or a Hospice.

Hospital Admission means the period between the time of Your 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 You are admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time he is confined in the Hospital, We shall consider the admission a Hospital Admission.

Bed patient means confinement in a bed accommodation located in a portion of a Hospital which is designed, staffed and operated to provide acute, short-term Hospital care on a 24-hour basis; the term does not include confinement in a portion of the Hospital designed, staffed and operated to provide long-term institutional care on a residential basis.
INDTXDF501

Identification Card means the card issued to the Subscriber indicating pertinent information applicable to his coverage under this Policy, including applicable Copayment Amounts and Prescription Drug Deductible.

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

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

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

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

a. Room and board charges. If You are confined in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge will *not* be an Eligible Expense.
b. All other usual Hospital services which are Medically Necessary and consistent with Your condition. Personal items are *not* included as Eligible Expenses.

Legend Drugs means drugs, biologicals, or compound prescriptions which are required by law to have a label stating "Caution-Federal Law Prohibits Dispensing Without a Prescription" and which are approved by the U.S. Food and Drug Administration (FDA) for at least one indication.
INDTXDF600

Maintenance Drugs means drugs prescribed for chronic conditions and are taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

Marriage and Family Therapy means the provision of professional therapy services to individuals, families, or married couples, single 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.

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

Medical Social Services means those social services relating to the treatment of Your medical condition. Such services include, but are not limited to assessment of:

a. The social and emotional factors related to Your Sickness, need for care, response to treatment and adjustment to care; and
b. The relationship of Your medical and nursing requirements to the home situation, financial resources, and available community resources.

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

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

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

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

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

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

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
INDTXDF700

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

Network means a group of Physicians, Specialists, Other Providers, Hospitals and other health care facilities who have executed a managed care agreement with Us for the provision of health care to You as covered under this Policy.

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

Network Physician means a Physician or Professional Other Provider who has executed a managed care agreement with Us for the provision of health care to You as covered under this Policy.

Network Provider means a Hospital, Physician, or Other Provider that has executed a managed care agreement with Us for the provision of care to You as covered under this Policy.

Non-Participating Pharmacy means a Pharmacy which has not entered into an agreement to provide prescription drug services to You under **Article V - Your Pharmacy Benefits**.

Non-Preferred Brand Name Drug means a Brand Name Drug which does not appear on the Preferred Brand Name Drug List but has a therapeutic equivalent that is listed in the Preferred Brand Name Drug List.
INDTXDF800

Oral Surgery means maxillofacial surgical procedures limited to:

a. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
b. Incision and drainage of facial abscess;
c. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
d. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded in **Article VI - Limitations and Exclusions** of this Policy.

Organic Brain Disease means the diagnosis or treatment of a mental disease, disorder or condition resulting from injury to or degeneration of the central nervous system as defined *in the Diagnostic and Statistical Manual III-R* or the *International Classification of Diseases, Ninth Revision* (ICD-9). This includes Organic Psychotic Conditions ICD-9 Diagnostic Codes 290-294, which includes dementias (290), alcohol induced mental disorders (291), drug induced mental disorders (292), transient organic mental disorders due to conditions classified elsewhere (293), persistent mental disorders due to conditions classified elsewhere (294); and Specific Nonpsychotic Mental Disorders due to Brain Damage ICD-9 Diagnostic Code 310.

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

a. **Facility Other Provider** — an institution or entity, only as listed:
   (1) Durable Medical Equipment Provider
   (2) Home Health Agency
   (3) Home Infusion Therapy Provider
   (4) Hospice
   (5) Imaging Center
   (6) Independent Laboratory
   (7) Prosthetic/Orthotics Provider
   (8) Renal Dialysis Center
   (9) Skilled Nursing Facility
   (10) Therapeutic Center

b. **Professional Other Provider** — a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
   (1) Advanced Practice Nurse
   (2) Doctor of Chiropractic
   (3) Doctor of Dentistry
   (4) Doctor of Optometry
   (5) Doctor of Podiatry
   (6) Doctor in Psychology
   (7) Licensed Acupuncturist
   (8) Licensed Audiologist
   (9) Licensed Clinical Social Worker
   (10) Licensed Dietitian
   (11) Licensed Hearing Instrument Fitter and Dispenser
   (12) Licensed Physical Therapist
   (13) Licensed Occupational Therapist
   (14) Licensed Speech-Language Pathologist
   (15) Nurse First Assistant

(16) Physician Assistant
(17) Surgical Assistant

Such terms as used herein, unless otherwise defined in this Policy, 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.

Orthotic Devices means a custom-fitted or custom-fabricated medical device that is applied to correct a deformity, improve function or relieve symptoms of a disease.

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

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

Out-of-Pocket Limit means the cumulative dollar amount of most Eligible Expenses incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan.

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.
INDTXDF900

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

Participating Pharmacy means a Pharmacy which has entered into an agreement to provide prescription drug services to You under **Article V - Your Pharmacy Benefits**.

Pharmacy means:

a. A state licensed establishment where the practice of pharmacy occurs that is physically separate and apart from any Provider's office, and
b. Where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he practices.

Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians' Current Procedural Terminology Manua*l (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, ultra-sound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

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

Plan Service Area means the Texas statewide geographical area.

Policy Month means each succeeding monthly period beginning on the Effective Date.

Preexisting Condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 12 month period immediately preceding the Effective Date of Your 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 twelve-month period immediately preceding the Effective Date of the Your coverage hereunder.

Preferred Brand Name Drug means a Brand Name Drug which appears on the Preferred Brand Name Drug List.

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

Prescription Order means a written or verbal order from a Health Care Practitioner and/or Professional Other Provider to a pharmacist for a drug or device to be dispensed. Prescription Orders written by a Health Care Practitioner and/or Professional Other Provider located outside the United States to be dispensed in the United States are not covered under this Policy unless the drug or device is deemed to be Medically Necessary.

Proof of Loss means written evidence of a claim including:

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

b. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim; and

c. Correct diagnosis code(s) and procedure code(s) for the services and items.

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

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

Provider means a Hospital, Physician, Other Provider, or any other person, company, or institution furnishing to You a service or supply listed as an Eligible Expense in this Policy.
INDTXDF1002

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.

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 Cost means the costs of any Medically Necessary health care service for which benefits are provided under the Policy, without regard to whether You are participating in a clinical trial.

Routine patient care costs do not include:

a. 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;
b. 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;
c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
d. A cost associated with managing a clinical trial; or
e. The cost of a health care service that is specifically excluded from coverage under the Policy.

Sickness means illness or disease of a Participant which first manifests itself after the Effective Date of this Policy, and occurs while this Policy is in force.

Skilled Nursing Facility means a facility which:

a. Is duly licensed by the state in which it is located and meets the standards established for such licensing, and is operated pursuant to the law;
b. Is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician;
c. Provides continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (RN);
d. Maintains a daily medical record on each patient; and
e. Is not, other than incidentally, any home, facility or part thereof used primarily for rest, a home or facility primarily for the aged, for the care of drug addicts or alcoholics, or a home or facility primarily used for the care and treatment of tuberculosis, mental diseases or disorders or custodial or education care.

Specialty Drugs means high cost prescription drugs that are generally prescribed for use in limited patient populations or indications. These drugs are typically injected, but may also include high cost oral medications. In addition, patient support and/or education and special dispensing or delivery may be required for these drugs; therefore, they are difficult to obtain via traditional pharmacy channels. A considerable portion of the use and costs are frequently generated through office-based medical claims and may require complex reimbursement procedures. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, contact the Pharmacy, refer to the Preferred Brand Name Drug List by accessing the Web site at www.bcbstx.com or call the Customer Service toll-free number on Your Identification Card.

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.

Subscriber means the person named on the Identification Card provided for with this Policy.

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

You, Your, Yourself means any Participant, including Subscribers and Dependents, covered under this Policy.
INDTXDF1100

Article II — Effective Date of Dependent Coverage

Newborn Child

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

To continue coverage beyond this 31-day period, the Subscriber must notify Us within 31 days of the birth and pay the required premium. If notification is received after the 31-day period, coverage shall be contingent upon the Subscriber making application for such coverage on a form approved by Us.

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

Court Ordered Coverage for Dependents

If the Subscriber has coverage under this Policy and if the Subscriber is required to provide coverage for a minor child as a result of a medical support order issued under the requirements of Section 14.061, Family Code, coverage will be automatic for the first 31 days following the date on which the court order is issued.

To continue coverage beyond 31 days, the Subscriber must make application for coverage on a form approved by Us and pay the required premium. If notification is received after the 31-day period, coverage shall be contingent upon the Subscriber making application for such coverage on a form approved by Us. The application form and satisfactory evidence of insurability must be submitted to Us at Our Administrative Office. Subject to Our acceptance of the application, evidence of insurability, and payment of the required premium, coverage shall become effective of the first day of the Policy Month following the date We accept the application.

Other Dependents

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

b. Coverage for a Dependent (other than a newborn child, or a court ordered child) of a Subscriber already having coverage under this Policy shall be contingent upon the Subscriber making application for such coverage on a form approved by Us. The application form and satisfactory evidence of insurability must be submitted to Us at Our Administrative Office. Subject to Our approval of the application, evidence of insurability, and the required premium, coverage shall become effective on the first day of the Policy Month following the date We approve the application.
INDTXED100

Article III — How Your Medical Benefits Work

Introduction

We have established a network of Providers to serve You throughout Texas. By using Providers in the Network, You will maximize the benefits available to You under this Policy. To get a current directory or inquire about a Network Provider, call the Customer Service telephone number shown on the back of Your Identification Card.

You have the freedom to use any health care Provider outside the Network and still receive benefits for covered services under this Policy. However, You will receive the lower level of benefits. See below for discussion on *ParPlan* Providers.
INDTXMW100

Allowable Amount

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

Review the definition of Allowable Amount in **Article I – Definitions** of this Policy to understand the guidelines used by Us.
INDTXMW200

Network Benefits

To receive Network Benefits under this Policy, care must be provided by a Network Provider. Refer to the Provider Directory to make Your selections. Network Providers will preauthorize services for You when required. You are generally not required to submit claim forms when You use a Network Provider.

If You choose a Network Provider, the Provider will bill Us - not You - for services provided.

The Provider has agreed to accept as payment, in full, the least of...

a. The billed charges, or
b. The Allowable Amount as determined by Us, or
c. Other contractually determined payment amounts.

You are responsible for paying any applicable Copayment Amounts, Deductibles and Coinsurance Amounts. You may be required to pay for limited or non-covered services. No claim forms are required.

Out-of-Network Benefits

If You choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If You go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level and You may have to submit claims for the services provided.

You will be responsible for…

a. Billed charges above the Allowable Amount, as determined by Us,
b. Coinsurance Amounts and Deductibles,
c. Preauthorization, and
d. Limited or non-covered services.
INDTXMW300

Continuity of Care

In the event You are under the care of a Network Provider at the time Your Provider stops participating in the Network and at the time of the Network Provider's termination, You are currently being treated for Special Circumstances such as a (1) disability, (2) acute condition, (3) life-threatening illness and are receiving treatment in accordance with the dictates of medical prudence, BCBSTX will continue providing coverage for that Provider's services at the Network Benefit level.

Special Circumstances means a condition such that the treating Physician or health care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to You. Special Circumstances shall be identified by

the treating Physician or health care Provider, who must: (1)request that You be permitted to continue treatment under the Physician's or Provider's care; and (2) agree not to seek payment from You of any amounts for which You would not be responsible if the Physician or Provider were still a Network Provider.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if You have been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect.

***ParPlan* Providers**

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

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

You will be responsible for any applicable Deductibles and Coinsurance Amounts as shown on Your Schedule of Coverage, and services that are limited or not covered under this Policy.

If Your Physician or Professional Other Provider does not participate in the *ParPlan*, You will be responsible for filing all claims for services rendered and You may be billed for services above Our Allowable Amount determination.
INDTXMW401

Medical Necessity

All services and supplies for which benefits are available under this Policy must be Medically Necessary as determined by Us. Charges for services and supplies that We determine are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or apply to the Out-of-Pocket Maximum.
INDTXMW500

Preauthorization Requirements

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

Preauthorization establishes, in advance, the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Policy. It ensures that the preauthorized care and services as described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits. Actual availability of benefits is always subject to other requirements of this Policy, such as Preexisting Conditions, limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

You, Your Physician, Provider of services, or a family member should call one of the toll-free numbers shown on the back of Your Identification Card. The call should be made between 7:30 a.m. and 6:00 p.m., Central Time, on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. We will follow up with Your Provider's office. In most cases Preauthorization is made within minutes while We are on the telephone with Your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

a. **Hospital Admissions**

You are required to have Your inpatient Hospital Admission preauthorized at least two working days prior to actual admission unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two working days after the admission or as soon as reasonably possible. When a Hospital Admission is preauthorized, a length-of-stay is assigned.

Preauthorization is not required for treatment of breast cancer unless an extension of the minimum length of stay is required. This Policy is required to provide a minimum length of stay in a Hospital for the treatment of breast cancer as follows:

Treatment of Breast Cancer
(1) 48 hours following a mastectomy, and

(2) 24 hours following a lymph node dissection.
If You require a longer stay than was first preauthorized, Your Provider may request an extension for the additional inpatient days. If an admission or extension is not preauthorized, benefits may be reduced or denied if We determine that the admission is not Medically Necessary or is Experimental/Investigational.

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

Failure to preauthorize 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 Out-of-Pocket Maximum. Additionally, We will review the Medical Necessity or Experimental/Investigational nature of Your claim.

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

Preauthorization is required for Medically Necessary *Extended Care Expense* and Home Infusion Therapy.

Preauthorization for *Extended Care Expense* and Home Infusion Therapy may be obtained by having the agency or facility providing the services contact Us to request Preauthorization. The request should be made:
(1) Prior to initiating Extended Care Expense or Home Infusion Therapy;
(2) When an extension of the initially preauthorized service is required; and
(3) When the treatment plan is altered.

We will review the information submitted prior to the start of *Extended Care Expense* or Home Infusion Therapy. We will send a letter to You and the agency or facility confirming Preauthorization or denying benefits. If *Extended Care Expense* or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the Preauthorization telephone number shown on the back of Your Identification Card.

If We have given notification that benefits for the treatment plan requested will be denied based on information submitted, claims will be denied.

Failure to preauthorize 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.

c. **Organ and Tissue Transplants**

Preauthorization is required for any organ or tissue transplant. Preauthorization 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. Preauthorization does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the preauthorized length-of-stay will not be denied on the basis of Medical Necessity or Experimental/Investigational.

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

INDTXMW600

Case Management

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

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

a. The Participant, his family, and the Physician agree; and
b. The benefits are cost effective; and
c. We anticipate future expenditures for Eligible Expenses, which may be reduced by such benefits.

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

INDTXMW700

Copayment Amounts and Deductibles

The benefits of this Policy will be available after satisfaction of any Copayment Amount, if applicable, and any Deductibles for Network Benefits and Out-of-Network Benefits, as shown on Your Schedule of Coverage.

a. **Copayment Amounts**
A Copayment Amount, as shown on Your Schedule of Coverage, will be required for most Physician office visits and/or consultations only when services are provided by a Network Physician or Professional Other Provider at the time You receive the services. If the services provided require You to return on a different day, a new Copayment Amount will be required for any office visits and/or consultation charges. The Copayment Amount is required even if the Out-of-Pocket Maximum has been met.

The following services are not payable under this Copayment Amount provision, but instead are considered *Medical-Surgical Expense*, subject to the Deductible and Coinsurance Amounts:
(1) Eligible Expenses for other covered charges provided at the time of the office visit or consultation (e.g. lab or X-ray);
(2) Surgery performed in the Physician's office;
(3) Physical therapy billed separately from an office visit;
(4) Occupational modalities in conjunction with physical therapy;
(5) Allergy injections billed separately from an office visit;
(6) Therapeutic injections; or
(7) Any services requiring preauthorization.

The Copayment Amount does not apply when an Out-of-Network Physician or Professional Other Provider renders the services.

b. **Deductibles**
The benefits of this Policy will be available after satisfaction of the applicable Deductibles for Network Benefits and Out-of-Network Benefits as shown on Your Schedule of Coverage.

(1) The applicable Deductible will be subtracted once during each Calendar Year from Your total combined *Inpatient Hospital Expense*, *Medical-Surgical Expense* and/or *Your Pharmacy Benefits,* as applicable*,* incurred for that Calendar Year.
(2) Any Eligible Expenses applied toward satisfying the Out-of-Network Deductible will apply toward satisfying the Network Deductible.
(3) Any Eligible Expenses applied toward satisfying the Network Deductible will not apply towards the Out-of-Network Deductible.
(4) When the total amount of the Deductible incurred in a Calendar Year by You under this Policy equals three times the individual Deductible amount as shown on Your Schedule of Coverage, all such Participants will have satisfied their Deductible for the remainder of that Calendar Year. No Participant will be allowed to contribute more than the individual Deductible amount to the family Deductible amount.

Out-of-Pocket Limit

a. When a Participant's Out-of-Pocket Limit during a Calendar Year equals the individual amount shown on Your Schedule of Coverage for Network or Out-of-Network Benefits, the benefit percentages automatically become 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant during the remainder of that Calendar Year.

b. When the total amount of the Out-of-Pocket Limit incurred in a Calendar Year by Participants under Your coverage equals the family Out-of-Pocket Limit shown on Your Schedule of Coverage, all such Participants will have satisfied their Out-of-Pocket Limit for the remainder of that Calendar Year. No Participant will be allowed to contribute more than the individual Out-of-Pocket Limit to the family Out-of-Pocket Limit.

c. Any Eligible Expenses applied toward satisfying the Out-of-Network Out-of-Pocket Limit will apply toward satisfaction of the Network Out-of-Pocket Limit.

d. Any Eligible Expenses applied toward satisfying the Network Out-of-Pocket Limit will not apply toward satisfaction of the Out-of-Network Out-of-Pocket Limit.

e. Most of Your payment obligations are considered as Coinsurance Amounts and are applied to the Out-of-Pocket Limit. Such Eligible Expenses do not include:

(1) Services, supplies, and charges limited or excluded by this Policy; or
(2) Expenses not covered because a benefit maximum has been reached; or
(3) Deductibles for Network Benefits and Out-of-Network Benefits; or
(4) Any Copayment Amounts under **Article V – Your Pharmacy Benefits**, or
(5) Any Deductibles under **Article V – Your Pharmacy Benefits**, or
(6) Any office visit Copayment Amounts, or
(7) Any benefits for Emergency Care, or
(8) Penalties for not preauthorizing *Inpatient Hospital Expense, Extended Care Expense* or Home Infusion Therapy.

INDTXMW900

Article IV — Your Medical Benefits

Benefits for *Inpatient Hospital Expense*

If *Inpatient Hospital Expense* incurred during each Hospital Admission is in excess of the applicable Deductible as shown on Your Schedule of Coverage, benefits will be provided as shown on Your Schedule of Coverage.

Each inpatient Hospital Admission requires preauthorization. Refer to **Article III - How Your Medical Benefits Work** of this Policy for additional information.

Services and supplies provided by an Out-of-Network Provider will receive Network Benefits when those services and supplies are not available from a Network Provider provided We acknowledge Your visit to an Out-of-Network Provider **prior** to the visit. Otherwise, Out-of-Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to Your Schedule of Coverage for information regarding applicable Coinsurance Amounts, Deductibles and penalties for failure to preauthorize that may apply to Your coverage.

INDTXMB100

Benefits for *Medical-Surgical Expense*

The benefit percentages of your total eligible *Medical-Surgical Expense* shown on the Schedule of Coverage, in excess of your Coinsurance Amounts, Copayment Amounts, and any applicable Deductibles, are BCBSTX's obligation under the Plan. The remaining unpaid *Medical-Surgical Expense,* in excess of the Coinsurance Amounts, Copayment Amounts, and any Deductibles, is your obligation to pay.

To calculate your benefits, subtract any applicable Copayment Amounts and Deductibles from your total eligible *Medical-Surgical Expense* and then multiply the difference by the benefit percentage shown on your Schedule of Coverage. Most remaining unpaid *Medical-Surgical Expense,* in excess of the Copayment Amounts and Deductible, is your Coinsurance Amount.

Medical-Surgical Expense shall include:

a. Services of Physicians or Professional Other Providers.
b. Services of a certified registered nurse-anesthetist (CRNA).
c. Physical Medicine Services as described in **Article IV – Your Medical Benefits** in this Policy.
d. Diagnostic x-ray and laboratory procedures.
e. Radiation therapy.
f. Rental of Durable Medical Equipment (DME) required for therapeutic use unless purchase of such equipment is required by Us.
g. Emergency Medical Transportation as described in **Article IV – Your Medical Benefits Special Benefit Provisions** in this Policy.
h. Anesthetics and administration when performed by someone other than the operating Physician or Professional Other Provider.
i. Oxygen and its administration provided the oxygen is actually used.
j. Blood, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for You.
k. Prosthetic Appliances, including replacements and repairs of such devices other than those necessitated by misuse or loss by the Participant.
l. Orthotic Devices that are consistent with the Medicare Benefits Policy Manual.
m. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back,

special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint.

n. Home Infusion Therapy. Any item of Home Infusion Therapy covered under this subsection will not be eligible for benefits under any other provision of this Policy.
o. Services or supplies used by You during an outpatient visit to a Hospital or a Therapeutic Center.
p. Outpatient Contraceptive Services and prescription contraception devices. However, coverage for prescription oral contraceptive medications is provided under **Article V - Your Pharmacy Benefits** in this policy.
q. Telehealth services and telemedicine medical services.

INDTXMB201

Benefits for *Extended Care Expense*

When *Extended Care Expense* is preauthorized as previously explained under **Article III – How Your Medical Benefits Work** of this Policy, benefits will be provided as shown on Your Schedule of Coverage. The Deductible will not apply to *Extended Care Expense*.

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

Services and supplies for *Extended Care Expense*:

a. For Skilled Nursing Facility

(1) All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
(2) Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
(3) Physical, occupational, speech, and respiratory therapy services by licensed therapists.

b. For Home Health Care

(1) Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
(2) Part-time or intermittent home health aide services which consist primarily of caring for the patient;
(3) Physical, occupational, speech, and respiratory therapy services by licensed therapists;
(4) Supplies and equipment routinely provided by the Home Health Agency.
(5) Benefits will not be provided for Home Health Care for the following:
    (a) Food or home delivered meals;
    (b) Social casework or homemaker services;
    (c) Services provided primarily for Custodial Care;
    (d) Transportation services;
    (e) Home Infusion Therapy;
    (f) Durable Medical Equipment.

c. Hospice Services

(1) For Home Hospice Services:

    (a) Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
    (b) Part-time or intermittent home health aide services which consist primarily of caring for the patient;
    (c) Physical, speech, and respiratory therapy services by licensed therapists;
    (d) Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

(2) For Facility Hospice Services:

    (a) All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
    (b) Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
    (c) Physical, speech, and respiratory therapy services by licensed therapists.

INDTXMB300

Special Benefit Provisions

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

Benefits for Treatment of Complications of Pregnancy

a. Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be the same as benefits for any other condition, subject to any applicable Deductible.
b. Services and supplies incurred by You for delivery of a child shall be considered Maternity Care and are not covered under this Policy.

INDTXMB400

Benefits for Emergency Room Care

Benefits for Emergency Room Care will be the same as benefits for any other condition. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact Your Network Physician before going to the Hospital emergency department or freestanding medical care facility. He can help You determine if You need Emergency Services and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether You require hospitalization or not, You should notify Your Network Physician as soon as reasonably possible, of any Emergency Services so he can recommend the continuation of any Medically Necessary services.

Network and Out-of-Network Benefits for Eligible Expenses for Emergency Services will be determined as shown on Your Schedule of Coverage. If admitted for the medical emergency immediately following the visit, preauthorization of the inpatient Hospital Admission will be required and *Inpatient Hospital Expense* will apply.

All Emergency Services, as described above, whether provided by a Network Provider or Out-of-Network Provider will be eligible for Network Benefits. If you continue to be treated by an Out-of-Network Provider after you receive Emergency Services and you can safely be transferred to the care of a Network Provider, only Out-of-Network Benefits will be available.

For Out-of-Network Emergency Services rendered by non-contracting Providers, the Allowable Amount shall be equal to the greatest of the following three possible amounts—not to exceed billed charges:

a. the median amount negotiated with Network Providers for Emergency Services furnished;
b. the amount for the Emergency Service calculated using the same method the Policy generally uses to determine payments for Out-of-Network services but substituting the Network cost-sharing provisions for the Out-of-Network cost-sharing provisions; or
c. the amount that would be paid under Medicare for the Emergency Service.

Each of these three amounts is calculated excluding any Network Coinsurance Amount imposed with respect to You.

INDTXMB600

Benefits for Professional Local Ground Ambulance or Air Ambulance Service

Benefits for *Medical-Surgical Expense* incurred for professional local ground ambulance or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of Your condition will be provided at the Network Benefits level, subject to any applicable Deductible.

INDTXMB700

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

Benefits for Eligible Expenses incurred for Cosmetic, Reconstructive or Plastic Surgery will be the same as benefits for any other condition for the following services only:

a. Treatment provided for the correction of defects incurred in an Accidental Injury.
b. Treatment provided for reconstructive surgery following cancer surgery.
c. Surgery performed on a newborn child for the treatment or correction of a congenital defect.
d. Surgery performed on a Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast.
e. Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy.

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

INDTXMB800

Benefits for Dental Services

a. Benefits for Eligible Expenses incurred for Dental Services will be the same as benefits for any other condition only for the following dental services:
   (1) Oral Surgery, as defined in **Article I – Definitions** of this Policy; 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, violent Accidental Injury to healthy, un-restored natural teeth and supporting tissues limited to such services and supplies provided:
      (a) For 24 months from the date of accident; or
      (b) To the termination date of this Policy,
      Whichever occurs first; except that an injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

b. Except as excluded in **Article VI – Limitations and Exclusions** of this Policy, for any other dental services for which You incur *Inpatient Hospital Expense* for a Medically Necessary Hospital Admission, benefits will be determined as described in the subsection entitled **Benefits for *Inpatient Hospital Expense***.

INDTXMB900

Benefits for Physical Medicine Services

Benefits for *Medical-Surgical Expense* incurred for Physical Medicine Services will be the same as benefits for any other condition, subject to any applicable Deductible.

INDTXMB1000

Benefits for Preventive Care Services

Benefits for Eligible Expenses incurred for the following Preventive Care Services received from a Network Provider will not be subject to Copayment Amounts, Coinsurance Amounts and Deductibles or dollar maximums:

a. evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
b. immunizations for Participants 8 years of age and over recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
c. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
d. with respect to women, such additional preventive care and screenings, not described in item a above, as provided for in comprehensive guidelines supported by the HRSA.

For purposes of this benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

The Preventive Care Services and immunizations described in items a through d above may change as the USPSTF, CDC, and HRSA guidelines are modified. For more information You may visit Our website at www.bcbstx.com or call the Customer Service at the telephone number shown on Your Identification Card.

Examples of Preventive Care Services include well child care, procedures, routine mammograms, colorectal cancer screenings, prostate cancer screenings, HPV/cervical cancer screenings, healthy diet counseling, obesity screening/counseling and smoking cessation counseling.

Examples of covered immunizations include Diphtheria, Hemophilus influenzae type b, Hepatitus A, Hepatitis B, Human papillomavirus, influenza, Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Polio, Rotavirus, Rubella, Tetanus, Varicella, and any other immunization that is required by law. Allergy injections are not considered immunizations under this benefit provision.

Preventive Care Services from an Out-of-Network Provider will be subject to Coinsurance Amounts, Copayment Amounts and Deductibles as shown on Your Schedule of Coverage.

Covered routine preventive services not included in this section may be subject to Coinsurance Amounts , Copayment Amounts and Deductibles and/or benefit maximums.

INDTXMB1100

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

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

Allergy injections are not considered immunizations under this benefit provision.
INDTXMB1200

Required Benefits for Newborn Screening Tests for Hearing Impairment
Benefits are available for *Medical-Surgical Expense* incurred by a Dependent child:

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

The Deductible will not apply; however, benefits will be subject to all other Policy provisions.
INDTXMB1300

Benefits for Treatment of Diabetes
Benefits for those Medically Necessary items for the monitoring and treatment of Diabetes, *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has written an order), and *Diabetes Management Services/Diabetes Self-Management Training* will be the same as benefits for any other condition. 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 glucose monitors designed to be used by blind individuals);
   (2) Insulin pumps (both external and implantable) and associated appurtenances, which include:
      - Batteries,
      - Skin preparation items,
      - Adhesive supplies,
      - Infusion sets,
      - Insulin cartridges,
      - Durable and disposable devices to assist in the injection of insulin, and
      - Other required disposable supplies;
   (3) Insulin infusion devices; and
   (4) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetic Supplies*

   (1) Test strips for blood glucose monitors,
   (2) Visual reading and urine test strips and tablets for glucose, ketones and protein,
   (3) Lancets and lancet devices,
   (4) Insulin and insulin analogs preparations,
   (5) Injection aids, including devices used to assist with insulin injection and 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 will be covered under **Article V – Your Pharmacy Benefits**.

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:

   (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 Policy 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.
INDTXMB1400

Benefits for Organ and Tissue Transplants

a. Subject to the conditions described below Network and Out-of-Network Benefits for Eligible Expenses to You (donor and/or recipient) by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

   (1) The transplant procedure is not Experimental/Investigational in nature;
   (2) Donated human organs or tissue are used;
   (3) The recipient is a Participant under this Policy. Benefits are also available to a live donor to the extent that benefits remain under the recipient's Policy after benefits for the recipient's expenses have been provided;
   (4) The transplant procedure is preauthorized as provided in **Article III – How Your Medical Benefits Work**;
   (5) You meet all of the criteria established by Us in Our written medical policy guidelines; and
   (6) You meet all of the protocols established by the Hospital in which the transplant is performed.

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

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

   Benefits will be available for:

   (1) A recipient who is covered under this Policy; and
   (2) A donor who is a Participant under this Policy; or
   (3) A donor who is not a Participant under this Policy.

c. Covered services and supplies include services and supplies provided:

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

(2) For the removal of organs or tissues from deceased donors; and
(3) For the transportation and storage of donated organs or tissues.

d. No benefits are available to You for the following services or supplies:

(1) Living and/or travel expenses of the live donor or recipient;
(2) Donor search and acceptability testing of potential living donors;
(3) Expenses related to maintenance of life for purposes of organ or tissue donation; and
(4) Purchase of the organ or tissue.
(5) Organs or tissue (xenograft) obtained from another species.

e. Preauthorization is required for any organ or tissue transplant. Review the Preauthorization Requirements in **Article III – How Your Medical Benefits Work** in this Policy for more specific information about preauthorization.

(1) Such specific preauthorization is required even if the patient is already a patient in a Hospital under another preauthorization authorization.
(2) At the time of preauthorization, We will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if We determines that an extension is Medically Necessary.

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

INDTXMB1500

Benefits for Routine Patient Care Costs for Participation 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:

a. the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
b. the National Institutes of Health;
c. the United States Food and Drug Administration;
d. the United States Department of Defense;
e. the United States Department of Veterans Affairs; or
f. 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.

INDTXMB1600

Benefits for Certain Therapies for Children with Development Delays

Medical-Surgical Expense benefits are provided for a Dependent child under 3 years of age with ***developmental delays*** for the necessary rehabilitative and habilitative therapies in accordance with an *Individualized Family Service Plan* issued by Texas Interagency Council on Early Childhood Intervention under Chapter 73, Texas *Human Resources Code*. Such therapies include:

a. Occupational therapy evaluation and services;
b. Physical therapy evaluations and services;
c. Speech therapy evaluations and services; and
d. 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 delay means a significant variation in normal development as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:

a. Cognitive development;
b. Physical development;
c. Communication development;
d. Social or emotional development; or
e. 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 child has reached age of 3, when services under the *individualized family service plan* are completed, Eligible Expenses, as otherwise covered under this Policy, will be available.
INDTXMB1700

Benefits for Treatment of Acquired Brain Injury
Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be the same as benefits for any other condition. Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation; neurobehavioral, neuropsychological, neurophysiological and psychophysiological testing and treatment; neurofeedback therapy, remediation, post-acute transition services and community reintegration services, including outpatient day treatment services, or any other post-acute treatment services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

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

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

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

To ensure that appropriate post-acute care treatment is provided, this Policy includes coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered who:

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

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.
INDTXMB1800

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.
INDTXMB1900

Article V — Your Pharmacy Benefits

Covered Drugs
Benefits for Medically Necessary Covered Drugs prescribed to treat You for a chronic, disabling, or life-threatening illness are available under this Policy if the drug:

a. Has been approved by the United States Food and Drug Administration (FDA) for at least one indication; and
b. Is recognized by the following for treatment of the indication for which the drug is prescribed
   (1) a prescription drug reference compendium approved by the Department of Insurance, or
   (2) substantially accepted peer-reviewed medical literature.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Policy, are eligible for benefits. Some equivalent drugs are manufactured under multiple brand names. In such cases, We may limit benefits to only one of the brand equivalents available. Benefits are available for Covered Drugs as indicated on Your Schedule of Coverage.
INDTXPD100

Benefits for Orally Administered Anticancer Medication

Benefits are available for Medically Necessary orally administered anticancer medication that is used to kill or slow the growth of cancerous cells. Coinsurance or a Copayment Amount will not apply to orally administered anticancer medication listed on the Managed Oral Cancer Drug List. To determine if a specific drug is on the Managed Oral Cancer Drug List, you may access the website at www.bcbstx.com/member/rx_drugs.html or contact Customer Service at the toll-free number on your Identification Card.
INDTXPD110

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

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

Any time a change in Your family takes place, it may be necessary for a new Identification Card to be issued to You.

Unauthorized, Fraudulent, Improper or Abusive Use of Identification Cards

a. The unauthorized, fraudulent, improper or abusive use of Identification Cards issued to You and Your covered family members will include, but not be limited to:
   (1) Use of the Identification Card prior to Your Effective Date;
   (2) Use of the Identification Card after Your date of termination of coverage under this Policy;
   (3) Obtaining prescription drugs or other benefits for persons not covered under this Policy;
   (4) Obtaining prescription drugs or other benefits which are not covered under this Policy;
   (5) Obtaining Covered Drugs for resale or for use by any person other than the person for whom the Prescription Order is written, even though the person is otherwise covered under this Policy;
   (6) Obtaining Covered Drugs without a Prescription Order or through the use of a forged or altered Prescription Order;
   (7) Obtaining quantities of prescription drugs in excess of Medically Necessary or prudent standards of use or in circumvention of the quantity limitations of this Policy;
   (8) Obtaining prescription drugs using Prescription Orders for the same drugs from multiple Providers;
   (9) Obtaining prescription drugs from multiple Pharmacies through use of the same Prescription Order.

b. The unauthorized, fraudulent, improper or abusive use of Identification Cards by You can result in, but is not limited to, the following sanctions being applied to all Participants covered under Your coverage:
   (1) Denial of benefits;
   (2) Cancellation of coverage under this Policy for all Participants under Your coverage;
   (3) Limitation on the use of Identification Card to one designated Participating Pharmacy of Your choice;
   (4) Recoupment from You or any of Your covered family members of any benefit payments made;
   (5) Pre-approval of drug purchases for all Participants covered under Your coverage;
   (6) Notice to proper authorities of potential violations of law or professional ethics.

INDTXPD200

Selecting a Pharmacy

When You need a Prescription Order filled, You can elect to go to a Participating Pharmacy or Non-Participating Pharmacy or use the mail-order Pharmacy. It is usually financially beneficial to You to utilize Participating Pharmacies, Specialty Drug Program and the mail-order Pharmacy.

Participating Pharmacy
When You go to a Participating Pharmacy:

a. present Your Identification Card to the pharmacist along with Your Prescription Order,
b. provide the pharmacist with the birth date and relationship of the patient,
c. sign the insurance claim log,
d. pay the Pharmacy Deductible, if applicable, and
e. pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference, if any.

Participating Pharmacies have agreed to accept as payment in full the least of:

a. the billed charges, or

b. the Allowable Amount as determined by BCBSTX, or
c. other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts and any pricing differences, when applicable. You may be required to pay for limited or non-covered services. No claim forms are required.

If You are unsure whether a Pharmacy is a Participating Pharmacy, You may access our website at www.bcbstx.com or call the Customer Service telephone number shown on the back of Your Identification Card. You must present Your Identification Card to Your Participating Pharmacy in order to receive full Policy benefits.
INDTXPD300

Non-Participating Pharmacy
If You have a Prescription Order filled at a Non-Participating Pharmacy, You must pay the Pharmacy the full amount of its bill and submit a claim form and itemized receipt to Us verifying that the prescription was filled. We will pay benefits for Covered Drugs as shown on Your Schedule of Coverage (but not more than 80% of the Average Wholesale Price, plus a dispensing fee), less the appropriate Pharmacy Deductible, Copayment Amount and any applicable pricing differences.
INDTXPD400

Mail-Order Pharmacy
The mail-order Pharmacy provides delivery of Covered Drugs directly to Your home address. If You elect to use the mail-order service, refer to Your Schedule of Coverage for applicable payment levels.

All items that are covered under the mail-order Pharmacy are the same items that are covered under retail Pharmacy and are subject to the same limitations and exclusions. Items covered through a specialty Pharmacy will not be covered through the mail-order Pharmacy. NOTE: Prescription drugs and other items may not be mailed outside the United States.

The mail-order Pharmacy has been selected to fill and deliver maintenance (long-term) medications. You are encouraged to fill these maintenance medications through mail order.

Some drugs may not be available through the mail-order Pharmacy. If You have any questions about this mail-order service, need assistance in determining the amount of Your payment, or need to obtain the mail-order prescription claim form, You may access the website at www.bcbstx.com or call the Customer Service telephone number shown on the back of Your Identification Card. Mail the completed form, Your Prescription Order(s) and payment to the address indicated on the form.

If You send an incorrect payment amount for the Covered Drug dispensed, You will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.
INDTXPD501

Specialty Drugs Program
The Specialty Drug delivery service integrates Specialty Drug benefits with Your overall medical and prescription drug benefits. This program provides delivery of medications directly to Your Health Care Practitioner administration location or to the home of the Participant that is undergoing treatment for a complex medical condition. Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the specialty pharmacy program.

The specialty drugs program delivery service offers:
a. Coordination of coverage between You, Your Health Care Practitioner and Us,
b. Educational materials about the patient's particular condition and information about managing potential medication side effects,
c. Syringes, sharps containers, alcohol swabs and other supplies with every shipment for FDA approved self-injectable medications, and
d. Access to a pharmacist for urgent medication issues 24 hours a day, 7 days a week, 365 days each year

A list identifying these specialty drugs is available by accessing the website at www.bcbstx.com or calling the Customer Service telephone number shown on the back of Your Identification Card. Your cost is indicated on the Schedule of Coverage. You will also be responsible for any Deductible amounts that may apply to Your coverage.
INDTXPD600

Pharmacy Discount Program
Drug manufacturers may offer coupons or other drug discounts or rebates to You, which may impact the benefits provided under this program. The total benefits payable will not exceed the balance of the Allowable Amount remaining after all drug coupons, rebates or other drug discounts have been applied. You agree to reimburse Us any excess amounts for benefits that We have paid and for which You are not eligible due to the application of drug coupons, rebates or other drug discounts.
INDTXPD700

Copayment Amounts
The Copayment Amounts applicable to Your coverage are shown on Your Schedule of Coverage. The Copayment Amount You pay depends on whether Your prescription is filled by a retail Pharmacy or through the mail-order Pharmacy and the type of drug dispensed. If the drug dispensed is a:

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

INDTXPD800

How Preferred Drug Pricing Difference Applies
When Your Health Care Practitioner has marked the Prescription Order "Brand Necessary," the pharmacist may *only* dispense the brand name drug and You pay the appropriate Preferred Brand Name Drug Copayment Amount.

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

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

INDTXPD900

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

INDTXPD1000

Day Supply
Benefits for Covered Drugs are provided up to the maximum day supply limit as indicated on Your Schedule of Coverage. The Copayment Amounts applicable for the designated day supply of dispensed drugs are also indicated on Your Schedule of Coverage. We have the right to determine the day supply. Payment for benefits covered under this Policy may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum day supply limitation.

INDTXPD1100

Quantity Versus Time Limit
Benefits will be provided for prescription drugs dispensed in the following quantities:

a. Retail Pharmacy and specialty Pharmacy - Up to a **30-day supply or 120 units (e.g. pills)**, whichever is less, for "non-maintenance" and Specialty Drugs;
b. Mail-order Pharmacy - Up to a **90-day supply or 360 units (e.g. pills)**, whichever is less, for nitroglycerin, natural thyroid products, and other drugs designated by Us as "maintenance" Legend Drugs.

Benefits are not provided under this Policy for charges for prescription drugs dispensed in excess of the above stated amounts.

If You are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before You intend to leave. (Extended supplies or vacation override are not available through the mail-order Pharmacy but may be approved through the retail Pharmacy only. In some cases, You may be asked to provide proof of continued enrollment eligibility under the retail Pharmacy.)

INDTXPD1200

Prescription Drug Preauthorization Process
We have designated certain drugs which require prior approval (preauthorize) in order for benefits to be available under this Policy. Preauthorization helps to assure that Your Prescription Drug meets Our guidelines for Medical Necessity for the condition being treated.

A form of preauthorization is our Step Therapy program - a "step" approach to providing benefits for certain medications Your Health Care Practitioner prescribes for You. This means that You may first need to try one or more "prerequisite" medications before certain high-cost medications are approved for coverage under **Your Pharmacy Benefits**.

If Your Health Care Practitioner prescribes a drug requiring prior approval, You may obtain Your prescription from a Participating Pharmacy by following one of the following steps:

a. **You may obtain approval prior to going to the Pharmacy to have Your prescription filled**.

A list of medications which require preauthorization, Step Therapy medications and possible alternatives are available to You and Your Health Care Practitioner on our website at www.bcbstx.com or call the Customer Service telephone number shown on the back of Your Identification Card. If Your Health Care Practitioner prescribes a drug which requires prior approval, You or the Health Care Practitioner may request preauthorization by calling the Customer Service telephone number shown on the back of Your Identification Card.

Please keep in mind that the listing of drugs requiring preauthorization will change periodically as new drugs are developed or as required to assure Medical Necessity.

When You present Your prescription to a Participating Pharmacy, along with Your Identification Card, the pharmacist will submit an electronic claim to BCBSTX to determine the appropriate benefits.

If the preauthorization request is approved prior to Your trip to the Participating Pharmacy, Your pharmacist will dispense the Prescription Drug or Covered Drug as prescribed and collect any applicable Copayment Amount.

If the preauthorization request was denied, the pharmacist will receive an electronic message indicating that benefits are not available for the drugs. You will be responsible for the full cost of Your prescription.

b. **Your Participating Pharmacy may begin the preauthorization process for You.**

If You do not request approval of a drug before You go to the Pharmacy to have Your prescription filled, Your pharmacist will begin the preauthorization process when You present Your Identification Card with Your Prescription Order. When the pharmacist submits Your claim electronically, he/she will receive a message indicating that preauthorization is required.

At this point, You may request a three-day supply of the drug while We complete the approval process. Your pharmacist will collect the appropriate Copayment Amount from You at the time of purchase.

Once the three-day supply has been used, You may return to the Pharmacy to obtain the remainder of Your Prescription Order. The Participating Pharmacy will resubmit the claim electronically to determine whether the preauthorization request has been approved or denied.

a. If preauthorization is approved for the drug, You may return to the Pharmacy to obtain the full Prescription Order, subject to any Copayment Amount applicable to the balance of the drug quantity dispensed.
b. If the preauthorization is denied, You may obtain Your Prescription Order by paying the full cost for the drugs.
c. Regardless of Our decision, You will be notified in writing regarding the outcome of Your preauthorization approval request.

If You purchase Your prescriptions from a Non-Participating Pharmacy, or if You do not have Your Identification Card with You when You purchase Your prescriptions, it will be Your responsibility to pay the full cost of the prescription drugs and to submit a claim form (with Your itemized receipt) to receive any benefits available under **Your Pharmacy Benefits**. Send the completed claim form to:

Blue Cross and Blue Shield of Texas
Prescription Drug Claims
P.O. Box 14624
Lexington, KY 40512-4624

If the drug You received is one which requires prior approval, We will review the claim to determine if preauthorization approval would have been given. If so, benefits will be processed in accordance with Your prescription drug coverage. If the preauthorization approval is denied, no benefits will be available for the Prescription Order.

To view a listing of the drugs which are included in the preauthorization/Step Therapy program or have questions about Step Therapy or any other aspect of the preauthorization process, please visit website at www.bcbstx.com/provider or call the Customer Service telephone number shown on the back of Your Identification Card.
INDTXPD1300

Article VI - Limitations and Exclusions

Medical Limitations and Exclusions

The benefits as described in Article IV – Your Medical Benefits of this Policy are not available for:

a. Any services or supplies for Eligible Expenses incurred for a Preexisting Condition during a period of 12 months beginning with Your Effective Date under this Policy. This Preexisting Condition exclusion shall not apply to You if:
   (1) You are under the age of 19; or
   (2) You were 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 Your Effective Date of coverage under this Policy, excluding any waiting periods.

   If You do not have aggregate Creditable Coverage totaling 18 months, 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 (1) the first day coverage is effective under this Policy if there is not a waiting period, or (2) the day the applicant files a substantially complete application for coverage if there is a waiting period.
b. Any services and supplies provided to You for Maternity Care.
c. 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.
d. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by Us.
e. Any services and supplies for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law; or any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or any laws, regulations or established procedures of any county or municipality, except as provided in Article VIII, Section 8. This Subsection e shall not be applicable to any legislation, which specifies that the benefits of this Policy shall be deducted from the benefits available under such legislation.

INDTXME100

f. Any charges for services and supplies provided which require Our approval when approval is not given.
g. Any services or supplies for which You are not required to make payment or for which You would have no legal obligation to pay in the absence of this or any similar coverage, (except treatment of mental illness or mental retardation by a tax supported institution).
h. Any services or supplies provided by a person who is related to You by blood or marriage.
i. 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.
j. Any charges as a result of suicide or attempted suicide, or intentionally self-inflicted injury, while sane or insane.

INDTXME200

k. 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.
l. 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 Your physical condition or the quality of medical care provided.
m. Any services or supplies provided during the course of a Hospital Admission or an admission in a Facility Other Provider which commences before You are covered as a Participant hereunder; or any services or supplies provided after the termination of Your coverage, **except** as may be provided in **Article VII – Termination of Coverage** of this Policy.
n. Any services or supplies provided for Dietary and Nutritional Services, **except** as may be provided in this Policy for:
   (1) An inpatient nutritional assessment program provided in and by a Hospital and approved by Us;
   (2) ***Treatment of Diabetes***; and
   (3) Dietary or nutritional evaluations provided in conjunction with ***Certain Therapies for Children with Developmental Delays.***
o. Any services or supplies for Custodial Care.

INDTXME300

p. Any services or supplies provided in connection with a routine physical examination. This exclusion does not apply to the following **except** as may be provided for in the **Special Benefit Provisions** section in **Article IV – Your Medical Benefits** of this Policy:
   (1) ***Preventive Care Services;*** and
   (2) ***Certain Therapies for Children with Developmental Delays.***
q. Any services and supplies (**except** for Medically Necessary diagnostic and surgical procedures) for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships

of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

r. 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.

s. Any items of *Medical-Surgical Expense* incurred for dental care and treatments, dental surgery, or dental appliances, **except** as may be provided in **Article IV – Your Medical Benefits** of this Policy.

t. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, **except** as may be provided for in **Article IV – Your Medical Benefits** of this Policy.

INDTXME400

u. Any services or supplies provided for:
   (1) Treatment of myopia and other errors of refraction, including refractive surgery; or
   (2) Orthoptics or visual training; or
   (3) Eyeglasses, contact lenses or hearing aids, provided that intraocular lenses and cochlear implant devices shall be specific exceptions to this exclusion; or
   (4) Examinations for the prescription or fitting of eyeglasses, contact lenses or hearing aids, **except** as may be provided for in the **Special Benefit Provisions** section in **Article IV – Your Medical Benefits** of this Policy.

v. Any services or supplies for mental and nervous disorders, except for Organic Brain Disease as defined in **Article I - Definitions** of this Policy.

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

x. 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.

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

INDTXME500

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

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

bb. Travel, whether or not recommended by a Physician or Professional Other Provider, **except** for Emergency Medical Transportation otherwise covered hereunder.

cc. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if You have other health conditions which might be helped by a reduction of obesity or weight. This exclusion does not apply to healthy diet counseling or obesity screening/counseling.

dd. 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.

INDTXME600

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

ff. 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.

gg. Any services or supplies for routine foot care, such as:
   (1) The cutting or removal of corns or callouses, the trimming of nails (including mycotic nails) and other hygienic and preventive maintenance care in the realm of self-care, such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory or bedfast patients; and
   (2) Any services performed in the absence of localized illness, injury, or symptoms involving the foot; and

(3) Any treatment of a fungal (mycotic) infection of the toenail in the absence of:
  (a) Clinical evidence of mycosis of the toenail;
  (b) Compelling medical evidence documenting that the patient either:
    (i) Has a marked limitation of ambulation requiring active treatment of the foot; or
    (ii) In the case of a non-ambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment; and
    (iii) Excision of a nail without using an injectable or general anesthetic.

hh. Any drugs and medicines, **except** as may be provided for in **Article V – Your Pharmacy Benefits** , that are:
  (1) Dispensed by a Pharmacy and received by You while covered under this Policy,
  (2) Dispensed in a Provider's office or during confinement in a Hospital or other acute care institution or facility and received by the Participant for use on an outpatient basis,
  (3) Over-the-counter drugs and medicines; or drugs for which no charge is made,
  (4) Prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations,
  (5) Retin-A or pharmacological similar topical drugs, or
  (6) Smoking cessation prescription drug products requiring a Prescription Order.

ii. Any Speech and Hearing Services, **except** as may be provided for in the **Special Benefit Provisions** section in **Article IV – Your Medical Benefits** of this Policy for:
  (1) ***Extended Care Expense***;
  (2) ***Preventive Care Services***;
  (3) ***Newborn Screening Tests for Hearing Impairment*** ;and
  (4) ***Certain Therapies for Children with Developmental Delays***.

INDTXME700

jj. Any services or supplies for reduction mammoplasty.

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

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

mm. Any services or supplies provided for or in conjunction with a condition which has been specifically excluded for You as indicated in the Coverage Exclusion Rider which is attached to and made a part of this Policy.

nn. Any services or supplies not specifically defined as an Eligible Expense under **Article IV – Your Medical Benefits** of this Policy.

INDTXME801

Pharmacy Limitations and Exclusions

The benefits as described in Article V – Your Pharmacy Benefits of this Policy are not available for*:*

a. Drugs which by law do not require a Prescription Order from an authorized Health Care Practitioner (except insulin, insulin analogs, insulin pens, and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.

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

c. Administration or injection of any drugs.

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

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

INDTXDE100

f. Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare)), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any prescription drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law;

provided, however, that the exclusions of this Section (f) shall not be applicable to any coverage held by You for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

g. Any services provided or items furnished for which the Pharmacy normally does not charge.
h. Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Copayment Amount provided under this Policy.
i. Infertility medications and fertility medications; prescription contraceptive devices, non-prescription contraceptive materials, (**except** prescription oral contraceptive medications which are Legend Drugs). However, coverage for prescription contraceptive devices is provided under the medical portion of this Policy.
j. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.

INDTXDE200

k. Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made for the drugs.
l. Covered Drugs dispensed in quantities in excess of the amounts stipulated in **Article V – Your Pharmacy Benefits** of this Policy, or refills of any prescriptions in excess of the number of refills specified by the Health Care Practitioner or by law, or any drugs or medicines dispensed more than one year following the Prescription Order date.
m. Legend Drugs which are not approved by the U.S. Food and Drug Administration (FDA).
n. Fluids, solutions, nutrients, or medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting; drugs given through routes other than subcutaneously in the home setting. This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases. 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.
o. Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
p. Drugs prescribed and dispensed for the treatment of mental or nervous disorders except Organic Brain Disease as defined in the Policy.

INDTXDE300

q. Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
r. Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
s. Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under this Policy, or for which benefits have been exhausted.
t. Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
u. Services and supplies for smoking cessation programs and the treatment of nicotine addiction.

INDTXDE400

v. Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
w. Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by Us.
x. Athletic performance enhancement drugs.
y. Drugs to treat sexual dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.
z. Compound Drugs as defined in **Article I - Definitions** of this Policy.

INDTXDE500

aa. Some equivalent drugs are manufactured under multiple brand-names. In such cases, We may limit benefits to only one of the brand equivalents available. If You do not accept the brand that is covered under this Policy, the brand name drug purchases will not be covered under any benefit level.
bb. Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
cc. Shipping, handling, or delivery charges.
dd. Prescription drugs required for international travel or work.
ee. Nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant.
ff. Drugs which are repackaged by anyone other than the original manufacturer.

INDTXDE601

Article VII – Guaranteed Renewability and Termination of Coverage

This Policy is renewable at the option of the Subscriber unless terminated as discussed below.

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

a. On the last day of the last period for which the premium for this Policy has been paid to Us, subject to the Grace Period provided in **Article VIII – General Provisions**; or
b. On the last day of any Policy Month upon written request for termination of this Policy made by the Subscriber and received by Us prior thereto; or
c. On the Policy Date for fraudulent or intentional misrepresentation of a material fact; or
d. On the date of death of the Subscriber; or
e. On the date following 90 days advance notice by Us to the Subscriber, but only if We are terminating all other Form No. PPO-SELCHOICE-7 Plan Policies; provided that We act uniformly without regard to any Health-Status Related Factor of covered individuals and offer any hospital, medical or surgical insurance coverage on a guaranteed issue basis to all applicants at the time of discontinuance of this Policy.
f. In the event this Policy is terminated in accordance with the provisions of Subsection e above, a Participant does not elect to purchase another individual hospital, medical or surgical insurance policy, coverage for any continuous illness or injury of a Participant which commenced while this Policy was in force shall, at termination, continue during the continuous Total Disability of the Participant and shall be limited to:
   (1) The duration of the policy benefit period: or
   (2) Payment of maximum benefits, if applicable, under this Policy; or
   (3) A period not less than 90 days.

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

g. We may elect to terminate all individual hospital, medical or surgical coverage plans delivered or issued for delivery in this State, but only if We:
   (1) Notify the Texas Department of Insurance Commissioner not later than 180 days prior to the date coverage under the first individual hospital, medical or surgical health benefit plan terminates;
   (2) Notify each covered Participant not later than 180 days prior to the date on which coverage terminates for that Participant; and
   (3) Act uniformly without regard to any Health-Status Related Factor of covered individuals or Dependents of covered individuals who may become eligible for coverage.

In addition to the provisions above, the coverage of any Dependent under this Policy shall terminate on the earliest of the following dates:

a. At the end of the Policy Month in which the Dependent ceases to be a Dependent as defined in **Article I-Definitions**, of this Policy, provided that:
   (1) If such date falls within a period for which We have accepted premium, coverage shall not terminate until the last day of such period; or
   (2) Coverage for any child who is medically certified as Disabled and Dependent upon You shall not terminate upon reaching age 26 if the child continues to be both: (a) Disabled, and (b) chiefly dependent on You for support and maintenance.
   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 Policy and before the child attains 26. You must submit satisfactory proof of the disability and dependency to Us within 31 days following the child's attainment of age 26. As a condition to the continued coverage of a child as a Disabled Dependent beyond age 26, 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 26.
b. On the date of death of the Dependent; or
c. On the last day of any Policy Month on written request for termination of the Dependent's coverage made by the Subscriber and received by Us prior thereto; or
d. On the last day of any Policy 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 all policies are not renewed or not continued uniformly without regard to any Health Status Related Factor of covered individuals. This requirement does not apply to a child whose coverage under the Policy is required by a medical support order.

Notwithstanding the provisions above, within 30 days of the death of the Subscriber:

a. If there is a surviving spouse, all remaining eligible Dependents may jointly elect in written notice to Us to continue this Policy with the surviving spouse as Subscriber.
b. If there is no surviving spouse, each Dependent may elect in written notice to Us to continue this Policy in his own name.

Notwithstanding the provisions above, within 30 days of a divorce, 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 Policy will have the same Effective Date as the Policy under which coverage was afforded prior to the loss of coverage. The rights provided under this Section shall terminate if We do not receive the application within the 30-day period.
INDTXTM101

Article VIII — General Provisions

Change of Beneficiary: The right to change a beneficiary is reserved for the Subscriber and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

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

Disclaimer: We will not be liable for any act or omission by any Hospital, Physician, or Other Provider, their agents or employees, in caring for You receiving services covered under this Policy, 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 You, and are available only for Sickness or injury acceptable to such Hospital, facility, or other institution.

Disclosure Authorization:

a. In consideration of Our having waived physical examination in connection with the application, the Subscriber, on behalf of all Participants, shall be deemed to have authorized any attending Physician, Other Provider or Hospital to furnish Us all information and records or copies of records relating to the diagnosis, treatment, or Your care under this Policy; and You shall, by asserting claim for benefits hereunder, be deemed to have waived all provisions of law forbidding the disclosure of such information and records in accordance with state and federal law.
b. As a condition to the continued coverage of a child as a disabled Dependent beyond the age of 26. 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 26.

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.

Grace Period: A Grace Period of: (a) ten days for monthly, or (b) 31 days for quarterly payment of premiums shall be allowed from the due date of each premium payment, during which Grace Period this Policy will continue in force, subject to its termination in accordance with the provisions hereof.
INDTXGP100

Legal Actions: No action at law or in equity shall be brought to recover on this Policy 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 Policy.

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

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

Notice of Claim: The Subscriber shall give or cause to be given written notice to Us at Our Administrative Office at P.O. Box 3236, Naperville Illinois 60566-7236 or Our duly authorized agent within 30 days or as soon as reasonably possible after You receive any of the services for which benefits are provided herein. Notice given to any Hospital by You at the time of admission as a patient shall satisfy this requirement.
INDTXGP200

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

Payment of Benefits:

a. When benefits are payable, We may choose to pay the Subscriber or the Provider with certain exceptions. Written contracts between Us and certain Providers may require payment directly to them. Payment to the Provider discharges Our responsibility to You for any benefits available under this Policy.
b. Except as provided above, the rights and benefits of this Policy shall not be assignable, either before or after services and supplies are provided. However, if a written assignment of benefits is made by You to a Provider and the written assignment is delivered to Us with the claim for benefits, We will make any payment directly to the Provider.
c. It is understood and agreed that the allowances described in **Article IV – Your Medical Benefits** or **Article V – Your Pharmacy Benefits** for services and supplies furnished by a Provider whom We do not directly contract with: (1) are not intended to and do not fix their value of the services of the Provider; and (2) relate to or regulate their value. The Provider may make its regular charge. The allowances are merely to apply as credits.
d. Any benefits payable to the Subscriber shall, if unpaid at the Subscriber's death, be paid to the Subscriber's beneficiary; if there is no beneficiary, then such benefits shall be paid to the Subscriber's estate.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting indemnity payments that may be prescribed in this Policy and effective at the time of payment. If such a designation or provision is not then effective, the indemnity will be payable to Your estate. Any other accrued indemnities unpaid at Your death may, at Our option, be paid either in accordance with the beneficiary designation or to Your estate. All other indemnities will be payable to You.

Subject to any written direction of the Subscriber, in the application or otherwise, all or a portion of any indemnity provided by this Policy on account of hospital, nursing, medical, or surgical services may, at Our option and unless the Subscriber requests otherwise in writing not later than the time of filing Proof of Loss, be paid directly to the Hospital or Provider providing the services. It is not required that the service be provided by a particular Hospital or Provider.

Physical Examinations and Autopsy: We, at Our own expense, shall have the right and opportunity to examine Your person for whom claim is made, when and so often as We may reasonably require during the pendency of a claim hereunder and also in case of death, the right and opportunity to make an autopsy where it is not prohibited by law.
INDTXGP300

Policy; Amendments:

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

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

Policy Renewal Date: The Policy renewal date when the Subscriber's health care coverage under this Policy renews for another Calendar Year is December 1 of each year.

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

Premium Rebates and Premium Abatements:

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

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

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

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

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

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

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

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

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

Premiums:

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

To notify Us of any change in the Subscriber's place of residence, You may notify Us in writing or You may call Customer Service telephone number shown on the back of the Subscriber's Identification Cards within 30 days of the date of the change.

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

b. Notwithstanding the provisions of Subsection a, above, of this Section:
   (1) **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 Policy shall automatically change to the rate applicable to the new place of residence effective on the first day of the Policy Month following the date of such change in residence. If such change is to a lower premium rate and the Subscriber fails to notify Us 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 Us.
   (2) **Age:** If the Subscriber and/or the Subscriber's spouse attain an age which results in an increased premium rate, the premium applicable to this Policy shall automatically change to the rate applicable to the new age effective on the first day of the Policy Month following the Subscriber and/or the Subscriber's spouse's birthday.
   (3) **Changes in Benefits:** The Subscriber may request a change in his benefits under this Policy by making application for such change on an application form approved by Us.

   If the request is for a lower Deductible, the application form and satisfactory evidence of insurability must be submitted to Us at Our Administrative Office. Subject to Our approval of the application, satisfactory evidence of insurability and payment of the required new premium, coverage shall become effective on the first day of the Policy Month following the date We approve the application.

   If the Subscriber requests to increase the Deductible, the application form must be submitted to Us at Our Administrative Office. Subject to Our approval of the application and payment of the required new premium, coverage shall be come effective on the first date of the Policy Month following the date We approve the application and payment of the required premium.

Proof of Loss:

a. Except for services or supplies provided by a Network Provider, written Proof of Loss must be furnished to Our Administrative Office at P.O. Box 3236, Naperville Illinois 60566-7236, or Our duly authorized agent, no later than 90 days from the date that the services or supplies are provided to the Participant. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time, provided such proof is furnished as soon as reasonably possible and, in no event, except in the absence of legal capacity of the Subscriber, later than one year from the time proof is otherwise required.
b. Written Proof of Loss for services or supplies provided by a Network Provider must be furnished to Us by the Network Provider in strict compliance with the written contract between BCBSTX or another Blue Cross Plan and the Network Provider. In the event such written contract does not contain a time limitation for furnishing Proof of Loss, the provisions of Subsection a, above, shall be applicable.

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

Reinstatement: If default be made in the stipulated premium payments for this Policy, the subsequent acceptance of such premium payments by BCBSTX or Our duly authorized agents shall reinstate the Policy. For purposes of this provision, mere receipt and/or negotiation of a late premium payment does not constitute acceptance. The reinstated Policy shall cover only loss resulting from Accidental Injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than ten days after such date. In all other respects, the Subscriber and BCBSTX shall have the same rights hereunder as they had under the Policy immediately before the due date of the defaulted premiums, including the right of the Subscriber to apply the period of time this Policy 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.

Rescission of Coverage: Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact on the Participant's application will result in the cancellation of Your coverage (and/or Your Dependent(s) coverage) retroactive to the Effective Date, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, Blue Cross and Blue Shield of

Texas (BCBSTX) may deduct from the premium refund any amounts made in claim payments during this period and You may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation is effected. At any time when BCBSTX is entitled to rescind coverage already in force, BCBSTX may at its option make an offer to reform the policy already in force. This reformation could include, but not be limited to, the addition of exclusion riders, (this limitation does not apply to a Participant under 19 years of age) and a change in the rating category/level. In the event of reformation, the policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. Please refer to the Review of Claim Determinations for your appeal rights concerning rescission and/or reformation.
INDTXGP600

Review of Claim Determinations

a. **Claim Determinations**
When We receive a properly submitted claim, We have authority and discretion under this Policy to interpret and determine benefits in accordance with the Policy provisions. We will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing. You have the right to seek and obtain a full and fair review by Us of any determination of a claim, any determination of a request for preauthorization, or any other determination made by Us of Your benefits under this Policy.

If a Claim Is Denied or Not Paid in Full
On occasion, We may deny all or part of Your claim. There are a number of reasons why this may happen. We suggest that You first read the *Explanation of Benefits* summary prepared by Us; then review this Policy to see whether You understand the reason for the determination. If You have additional information that You believe could change the decision, send it to Us and request a review of the decision as described in **Claim Appeal Procedures** below.

If the claim is denied in whole or in part, You will receive a written notice from Us with the following information, if applicable:
- The reasons for determination;
- A reference to the benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of Our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Us;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an urgent care clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions
Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims, as defined below.

1. **Urgent Care Clinical Claim** is any pre-service claim that for benefits for medical care or treatment with respect to which the application of regular time periods for making a health claim determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with

knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.
3. **Post-Service Claim** is notification in a form acceptable to Us that a service has been rendered or furnished to You. This notification must include full details of the service received, including Your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which We may request in connection with services rendered to You.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If Your claim is incomplete, We must notify You of any additional information needed to complete Your claim within:	**24 hours**
If You are notified that Your claim is incomplete, You must then provide the additional information to Us within:	**48 hours** after receiving notice
BCBSTX must notify you of the claim determination (whether adverse or not):	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
if the initial claim is incomplete, within:	**48 hours** after the earlier of Our receipt of the additional information or the end of the period within which the additional information was to be provided

* You do not need to submit appeals of Urgent Care Clinical Claims in writing. You should call Us at the toll-free number listed on the back of Your Identification Card as soon as possible to appeal an Urgent Care Clinical Claim.

Note: If a proposed medical care or health care service requires preauthorization by Us, We will issue a determination no later than the third calendar day after Our receipt of the request. If you are an inpatient in a healthcare facility at the time the services are proposed, We will issue our determination within 24 hours after Our receipt of the request.

Pre-Service Claims

Type of Notice	Timing
BCBSTX must notify you of the claim determination (whether adverse or not):	
if We have received all information necessary to complete the review within:	**2 working days of our receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and** **3 calendar days of the request, if the claim is denied.***
If You require post-stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

Note: For claims involving services related to Acquired Brain Injury, We will issue our determination no later than 3 business days after We receive the request.

Post-Service Claims (Retrospective Review)

Type of Notice or Extension	Timing
If Your claim is incomplete, We must notify You within:	**30 days**
If You are notified that Your claim is incomplete, You must then provide completed claim information to Us within:	**45 days** after receiving notice
BCBSTX must notify you of the claim determination (whether adverse or not):	
if the initial claim is complete, within:	**30 days after receipt of the claim** *
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days if we extended the period, less any days already utilized by Us during our review***

* This period may be extended one time by Us for up to 15 days, provided that We both (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies You in writing, prior to the expiration of the initial 30−day period, of the circumstances requiring the extension of time and the date by which We expect to render a decision. If the period is extended because We require additional information from You or Your Provider, the period for Our making the determination is tolled from the date We send notice of extension to You until the earlier of: i) the date on which we receive the information; or ii) the date by which the information was to be submitted.

Concurrent Care
For benefit determinations relating to care that are being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of Your claim for benefits.

b. **Claim Appeal Procedures**

Claim Appeal Procedures - Definitions
An "**Adverse Benefit Determination"** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. If an ongoing course of treatment had been approved by Us and We reduce or terminate such treatment (other than by amendment) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

A "**Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by Us at completion of Our internal review/appeal process.

Expedited Clinical Appeals
If Your situation meets the definition of an expedited clinical appeal, You may be entitled to an appeal on an expedited basis. An **expedited clinical appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, as well as continued hospitalization or an Emergency Medical Condition. Before authorization of benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, We will provide You with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

Upon receipt of an expedited pre-service or concurrent clinical appeal, We will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, thief additional information is needed to review the appeal. We shall render a determination on the appeal within one working day from the date all information necessary to complete the appeal is received by Us, but no later than 72 hours after the appeal has been received by Us.

How to Appeal an Adverse Benefit Determination
You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by Us in accordance with the benefits and procedures detailed in Your Policy.

An appeal of an Adverse Benefit Determination may be requested orally or in writing by You or a person authorized to act on Your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about You except to Your authorized representative. To obtain an Authorized Representative Form, You or Your representative may call Us at the number on the back of Your ID card.

If You believe We incorrectly denied all or part of Your benefits, You may have Your claim reviewed. We will review the decision in accordance with the following procedure:

- Within 180 days after You receive notice of a denial or partial denial, You may call or write to Our Administrative Office. We will need to know the reasons why You do not agree with the denial or partial denial. Send Your request to:

  Claim Review Section
  Blue Cross and Blue Shield of Texas
  P. O. Box 660044
  Dallas, Texas 75266-0044

- We will honor telephone requests for information. However, such inquiries will not constitute a request for review.

- In support of Your claim review, You have the option of presenting evidence and testimony to Us. You and Your authorized representative may ask to review Your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after You receive notice of an Adverse Benefit Determination or at any time during the claim review process.

  We will provide You or Your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of Your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to You or Your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give You a change to respond. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal determination will be made by a Physician associated or contracted with Us and/or by external advisors, but who were not involved in making the initial denial of Your claim. Before You or Your authorized representative may bring any action to recover benefits the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by Us.

- If You have any questions about the claims procedures or the review procedure, write to Our Administrative Office or call the toll-free Customer Service Helpline number shown in this Policy or on Your Identification Card.

Timing of Appeal Determinations
We will render a determination on non-urgent concurrent pre-service appeals that do not require expedited review or preauthorization and post-service appeals as soon as practical, but in no event later than 30 days after the appeal has been received by Us.

For claims involving services related to Acquired Brain Injury, We will render an appeal determination within 3 business days after the appeal is received by Us.

Notice of Appeal Determination
We will notify the party filing the appeal, You, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice will include:
- A reason for the determination;
- A reference to the benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of Our external review processes (and how to initiate an external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by Us;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision;
- Your right, if applicable, to request external review by and Independent Review Organization; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman

If BCBSTX denies Your appeal, in whole or in part, or You do not receive a timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO) section below.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)
An "**Adverse Determination**" means a determination by Us or Our designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, is determined to be experimental or investigational, or does not meet Our requirement for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

This procedure (not part of the Complaint process) pertains only to appeals of Adverse Determinations. In addition, in life-threatening or urgent care circumstances, You are entitled to an immediate appeal to an IRO and are not required to comply with Our appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by Us may seek review of the decision by an IRO. At the time the appeal is denied, We will provide You, Your designated representative or Provider of record, information on how to appeal the denial, including the approved form, which You, Your designated representative, or Your Provider of record must complete. In life-threatening or urgent care situations, You, Your designated representative, or Your Provider of record may contact Us by telephone to request the review and provide the required information. For all other situations, You or Your designated representative must sign the form and return to Us begin the independent review process.

- We will submit medical records, names of Providers and any documentation pertinent to the decision of the IRO.
- We will comply with the decision by the IRO.
- We will pay for the independent review.

Upon request and free of charge, You or Your designee may have reasonable access to, and copies of, all documents, records and other information relevant to the claim or appeal, including:

- information relied upon to make the decision;
- information submitted, considered or generated in the course of making the decision, whether or not it was relied upon to make the decision;
- descriptions of the administrative process and safeguards used to make the decision;
- records of any independent reviews conducted by Us;
- medical judgments, including whether a particular service is Experimental/Investigational or not Medically Necessary or appropriate; and
- expert advice and consultation obtained by Us in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit You from pursuing other appropriate remedies, including: civil action, injunctive relief; a declaratory judgment or other relief available under law, if the requirement to exhaust the process for appeal and review places Your health in serious jeopardy.

For more information about the IRO process, call Texas Department of Insurance (TDI) on the IRO information line at (888) TDI-2IRO (834-2476), or in Austin call (512) 322-3400.
INDTXGP702

State Government Programs:

a. Benefits for services or supplies under this Policy 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 Chapter 1504 of the *Texas Insurance Code*.
b. All benefits paid on behalf of a child or children under this Policy must be paid to the Texas Department of Human Services where:
   (1) The Texas Department of Human Services is paying benefits pursuant to Chapter 31 or 32 of the *Human Resources Code*; and
   (2) The parent who is covered by this Policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and
   (3) We receive written notice at Our Administrative Office, affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.

Subrogation:

a. If We pay or provide benefits for You under this Policy, We are subrogated to all rights of recovery which You have in contract, tort or otherwise against any person, organization or insurer for the amount of benefits We have paid or provided. That means We may use the Subscriber's rights to recover money through judgment, settlement or otherwise from any person, organization or insurer.
b. For the purposes of this provision, Subrogation means the substitution of one person or entity (BCBSTX) in the place of another (any Participant covered under this Policy) with reference to a lawful claim, demand or right, so that he or she who is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.
c. **Right of Reimbursement:** In jurisdictions where subrogation rights are not recognized, or where subrogation rights are precluded by factual circumstances, We will have a right of reimbursement.
   If any Participant covered under this Policy recovers money from any person, organization or insurer for an injury or condition for which We paid benefits under this Policy, all Participants covered under this Policy agrees to reimburse Us from the recovered money for the amount of benefits paid or provided by Us. That means any Participant covered under this Policy will pay Us the amount of money recovered through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits We paid or provided.
d. **Right to Recovery by Subrogation or Reimbursement:** Any Participant covered under this Policy agrees to promptly furnish to Us all information concerning any Participant's rights of recovery from any person, organization or insurer and to fully assist and cooperate with Us in protecting and obtaining its reimbursement and subrogation rights. Any Participant covered under this Policy or their attorney will notify Us before settling any claim or suit so as to enable Us to enforce Our rights by participating in the settlement of the claim or suit. Any Participant covered under this Policy further agrees not to allow the reimbursement and subrogation rights BCBSTX to be limited or harmed by any acts or failure to act on the part of any Participant.

INDTXGP800

Time Limit on Certain Defenses:

a. After two years from Your Effective Date of coverage, no misstatements or omissions, except fraudulent misstatements or omissions, made in his application for coverage shall be used to void his coverage or to deny a claim for benefits on account of hospitalization or medical-surgical services provided after the expiration of such two-year period.
b. No claim for loss You have incurred under this Policy on account of hospitalization or medical-surgical services provided after the twelve-month period from the date of issue of this Policy 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 Your Effective Date of coverage under this Policy. This Subsection b shall not apply to a disease or physical condition for which a fraudulent misstatement or omission was made by the Subscriber in his application for coverage.

Time of Payment of Claims: Benefits payable under this Policy for any loss will be paid immediately upon receipt of due written Proof of Loss.
INDTXGP900

Amendments

An Amendment

Effective Date August 1, 2013

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

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

The **Definitions** section of Your Policy is amended by adding the following to the definition of **Allowable Amount**:

> ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount) -*** Notwithstanding the above, where applicable state or federal law requires another standard for a non-contracting claim, the Allowable Amount shall be the lessor of billed charge or the amount prescribed by law.

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

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

Jeffrey R Tikkanen
President, Retail Markets
Blue Cross and Blue Shield of Texas

Notices

Notice of Annual Meeting

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

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

(For Insurers declared insolvent or impaired on or after September 1, 2005)

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

It is possible that the Association may not cover your policy in full or in part due to statutory limitations.

Eligibility for Protection by the Association

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

- Residents of Texas at that time **(irrespective of the policyholder's residency at policy issue)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

- Present value of benefits up to a total of $100,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to $100,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for any one contractholder regardless of the number of contracts.

Aggregate Limit:

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

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage.

Texas Life, Accident, Health and Hospital
Service Insurance Guaranty Association
6504 Bridge Point Parkway, Suite 450
Austin, Texas 78730
800-982-6362 or www.txlifega.org

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

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your Contract with Blue Cross and Blue Shield of Texas, a Division of Health Care Services Corporation.

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred in conducting an annually medically required diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or screening using liquid-based cytology methods as approved by the United States Food and Drug Administration for the detection of human Papillomavirus.

If any person covered by this Plan has a question concerning the above, please call Blue Cross and Blue Shield of Texas at: 1-888-697-0683, or write to us at: P. O. Box 3236, Naperville, Illinois 60566-7236.

NOTICE OF MANDATED BENEFITS

This notice is to advise you of certain coverage and/or benefits provided in your health plan insured by Blue Cross and Blue Shield of Texas. This notice is required by legislation to be provided to you. *If you have questions regarding this notice, call Blue Cross and Blue Shield of Texas at 1-888-697-0683 or write us at P.O. Box 3236, Naperville, Illinois 60566-7236.*

Mastectomy or Lymph Node Dissection

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

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

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

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

Reconstructive Surgery After Mastectomy

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

a. All stages of the reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
c. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner determined to be appropriate in consultation with the covered person and the attending physician.

Deductibles, coinsurance and copayment amounts will be the same as those applied to other similarly covered *Inpatient Hospital Expense* or *Medical-Surgical Expense*, as shown on the Schedule of Coverage.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Prostate Cancer Detection Examinations

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

- A physical examination for the detection of prostate cancer; and

- A prostate-specific antigen test for each covered male who is:
  - At least 50 years of age; or
  - At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Inpatient Stay Following Birth of a Child Due to Complication of Pregnancy

Benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

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

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

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

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

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

Coverage for Tests for Detection of Colorectal Cancer

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

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

(b) a colonoscopy performed every ten years.

NOTICE

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

Form Number NTC-1731-0907 Stock Number 43984.0907

NOTICE OF COVERAGE FOR ACQUIRED BRAIN INJURY

This notice is to advise you of certain coverage and/or benefits provided in your health plan insured by Blue Cross and Blue Shield of Texas. This notice is required by legislation to be provided to you. *If you have questions regarding this notice, call Blue Cross and Blue Shield of Texas at 1-888-697-0683 or write us at P.O. Box 3236, Naperville, IL* 60566-7236.

Your health benefit plan coverage for an acquired brain injury includes the following services:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehaviorial, neurophysiological, neuropsychological and psychophysiological testing and treatment;
- Neurofeedback therapy and remediation;
- Post-acute transition services and community reintegration services, including outpatient day treatment services or other post-acute care treatment services; and
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

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

NOTICE TO BLUE CROSS AND BLUE SHIELD OF TEXAS

CONTRACT HOLDER

Out-of-Area Services

Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation, has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as “Inter-Plan Programs.” Whenever You obtain healthcare services outside of Our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside Our service area, You will obtain care from healthcare Providers that have a contractual agreement (i.e., are “participating Providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, You may obtain care from nonparticipating healthcare Providers. Our payment practices in both instances are described below.

BlueCard® Program

Under the BlueCard® Program, when You access covered healthcare services within the geographic area served by a Host Blue, BCBSTX will remain responsible for fulfilling Our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever You access covered healthcare services outside Our service area and the claim is processed through the BlueCard Program, the amount You pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for Your covered services; or
- The negotiated price that the Host Blue makes available to BCBSTX.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to Your healthcare Provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price BCBSTX uses for Your claim because they will not be applied retroactively to claims already paid.

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to Your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, We would then calculate Your liability for any covered healthcare services according to applicable law.

NOTICE TO BLUE CROSS AND BLUE SHIELD OF TEXAS

CONTRACT HOLDER

Liability Calculation Method Per Claim

The calculation of the Participant's liability on claims for covered healthcare services processed through the BlueCard Program will be based on the lower of the participating healthcare Provider's billed covered charges or the negotiated price made available to BCBSTX by the Host Blue.

Host Blues may use various methods to determine a negotiated price, depending on the terms of each Host Blue's healthcare Provider contracts. The negotiated price made available to BCBSTX by the Host Blue may represent a payment negotiated by a Host Blue with a healthcare Provider that is one of the following:

(i) an actual price. An actual price is a negotiated payment without any other increases or decreases, or

(ii) an estimated price. An estimated price is a negotiated payment reduced or increased by a percentage to take into account certain payments negotiated with the provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, provider refunds not applied on a claim-specific basis, retrospective settlements, and performance-related bonuses or incentives; or

(iii) an average price. An average price is a percentage of billed covered charges representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

Host Blues using either an estimated price or an average price may, in accordance with Inter-Plan Programs policies, prospectively increase or reduce such prices to correct for over- or underestimation of past prices (i.e., prospective adjustments may mean that a current price reflects additional amounts or credits for claims already paid to providers or anticipated to be paid to or received from providers). However, the amount paid by the Participant is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims. The BlueCard Program requires that the price submitted by a Host Blue to BCBSTX is a final price irrespective of any future adjustments based on the use of estimated or average pricing.

A small number of states require a Host Blue either (i) to use a basis for determining Participant liability for covered healthcare services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (ii) to add a surcharge. Should the state in which healthcare services are accessed mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, We would then calculate Participant liability in accordance with applicable law.

NOTICE TO BLUE CROSS AND BLUE SHIELD OF TEXAS

CONTRACT HOLDER

Return of Overpayments

Under the BlueCard Program, recoveries from a Host Blue or its participating healthcare Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, healthcare Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts. Recovery amounts determined in these ways will be applied in accordance with applicable Inter-Plan Programs policies, which generally require correction on a claim-by claim or prospective basis.

Non-Participating Healthcare Providers Outside BCBSTX Service Area

For non-participating healthcare Providers outside our Service Area, please refer to the Allowable Amount definition in the **Definitions** section of this Contract.

Texas Department of Insurance Notice

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

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

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

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

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

IMPORTANT TO YOUR COVERAGE

To pay less out-of-pocket expenses and to receive the higher level of benefits for your health care costs, it is to your advantage to use Network Providers. If you use Network Providers, you will not be responsible for any charges over the Allowable Amount as determined by BCBSTX. What follows is an example of how much you would pay if you use a Network Provider and how much you would pay if you use a non-contracting Out-of-Network Provider. To make the example easier to follow, assume the Allowable Amount is the same. (NOTE: In most cases, however, the non-contracting Allowable Amount will be less than the contracting Allowable Amount, meaning your total payment responsibility will be even greater.)

EXAMPLE ONLY

	In-Network 80% of eligible charges $250 Deductible	**Out-of-Network** 70% of eligible charges $500 Deductible
Amount Billed	$20,000	$20,000
Allowable Amount	$5,000	$5,000
Deductible Amount	$250	$500
Plan's Coinsurance Amount	$3,800	$3,150
Your Coinsurance Amount	$950	$1,350
Non-Contracting Provider's additional charge to you	None	$15,000[1]
YOUR TOTAL PAYMENT	**$1,200 to a Network Provider**	**$16,850 to a Non-contracting Out-of-Network Provider**

Even when you consult a Network Provider, ask questions about any of the Providers rendering care to you. If you are scheduled for surgery, for example, ensure that your Network surgeon will be using a Network facility for your procedure and a Network Provider for your anesthesia services.

[1] If you choose to receive services from an Out-of-Network Provider, inquire if he participates in a contractual arrangement with BCBSTX. Providers who do not contract with BCBSTX or any other Blue Cross and Blue Shield plan will bill the patient for expenses over the Allowable Amount. Please refer to the section entitled *PARPLAN* in the Contract.

BlueCross BlueShield of Texas

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

Blue Access for Members℠*

Your gateway to health information

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

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

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

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

Blue Access Mobile℠

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

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

Provider Finder

Easily search for physicians, specialists and hospitals

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

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

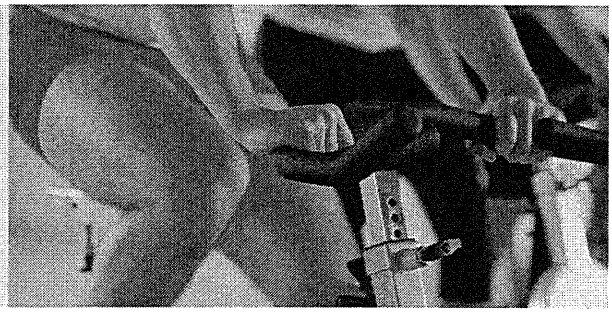
Download the free Provider Finder® App for Android or iPhone

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

52157.0413

Well onTarget℠

Motivation and guidance on the path to health and wellness



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

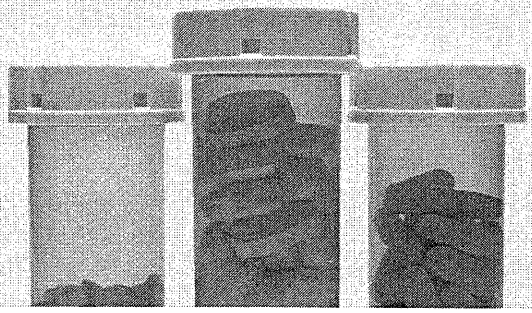
Well onTarget includes wellness programs such as:

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

Learn more at wellontarget.com.

Mail service for prescriptions

It's all about convenience



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

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

Blue365®

Member discount program

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

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

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

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

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

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

Life Time® Fitness

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

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

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

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

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

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

Travel with confidence

You're covered!

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

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

Learn more about taking care of your health

Facebook
facebook.com/
bluecrossblueshieldoftexas

Twitter
twitter.com/bcbstx

YouTube
youtube.com/bcbstx

Texas Department of Insurance Notice

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

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

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

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

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

BlueCross BlueShield of Texas

To Use or Disclose Protected Health Information (PHI)

Standard Authorization Form

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

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

II. Authorization and Purpose:

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

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

III. Specific Description of Information to be Used or Disclosed

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

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

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

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

Yes ☐

No ☐

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

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

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

IV. Expiration and Revocation

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

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

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

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

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

_____ _____

Signature Date: month/day/year

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

_____ _____

Personal Representative's Name Relationship to Individual

_____ _____ _____ _____

Personal Representative's Address City State ZIP

_____

Personal Representative's Area Code & Telephone Number

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

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

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

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

Prescription Drug Claim Form

See instructions on reverse.

BlueCross BlueShield of Texas

Patient Information

ID Number

Group Number –

Date of Birth / / ❑ Male ❑ Female

Patient Name (First, Last)

Street Address

City State ZIP

Patient's Relationship to Subscriber/Member:

❑ Self ❑ Spouse ❑ Dependent

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

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

Patient/Subscriber/Member or Legal Representative Signature

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

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

If yes, please provide Name of other Insurance:

Policy Number:

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

Subscriber/Member Information

Name (First, Last)

Pharmacy Information

Pharmacy Name

Pharmacy Address

City State ZIP

Prescription Claim Information

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

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

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

1 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

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

NPI Number

Prescription Cost $.

Balance Due $.

2 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

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

NPI Number

Prescription Cost $.

Balance Due $.

3 Rx Number

Date Filled / /

Quantity Day Supply

Name of Medication

NDC Number

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

NPI Number

Prescription Cost $.

Balance Due $.

X

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

Pharmacy/Prescription Information

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

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

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

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

EXAMPLE
of how to complete the Prescription Drug Claim Form.

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

Date Filled 0 1 / 1 2 / 0 5

Quantity 30 Day Supply 3 0

Name of Medication "Drug Name"

NDC Number 0 0 1 2 3 4 5 6 7 3 1

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

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

Prescription Cost $ 2 0 5 . 1 4

Balance Due $ 2 0 5 . 1 4

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

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

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

Compound Prescriptions
For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1

Pharmacy Receipts Only

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

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

Rx 2

Pharmacy Receipts Only

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

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

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

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

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

An Amendment

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

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

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

   Allowable Amount

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

An Amendment

Effective January 1, 2011

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

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

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

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

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

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

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

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

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

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

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

President of Blue Cross and Blue Shield of Texas

NOTICE

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

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

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

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

Effective October 1, 2008

Because You are moving from one Blue Cross and Blue Shield of Texas Individual Plan Insurance Contract to another, Your Contract is amended to provide that all 1) Deductibles, 2)Coinsurance Amounts, 3) Calendar Year maximum benefit amounts and 4) lifetime maximum benefit amounts in this new Contract shall be reduced in the amount of any of these benefits paid under the Subscriber's Blue Cross and Blue Shield of Texas Individual Plan Insurance Contract held with Us immediately prior to a Participant's Effective Date under this Contract.

President of Blue Cross and Blue Shield of Texas

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

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

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

Eligibility for Protection by the Association

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

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued.)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

Aggregate Limit:

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

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

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

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

IMPORTANT NOTICE

To obtain information or make a complaint:

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

  1-888-697-0683

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

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

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

  1-800-252-3439

- You may write the Texas Department of Insurance at:

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

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

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

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

  1-888-697-0683

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

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

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

  1-800-252-3439

- Puede escribir al Departmento de Seguros de Texas:

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

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

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

An Amendment

Effective Date September 1, 2011

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

Your Contract is amended as follows:

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

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

Benefits for Orally Administered Anticancer Medication

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

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

President of Blue Cross and Blue Shield of Texas

An Amendment

January 1, 2012

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

AMENDMENT TO THE CONTRACT

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

Premium Rebates and Premium Abatements:

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

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

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

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

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

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

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

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

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

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

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

President of Blue Cross and Blue Shield of Texas

An Amendment

Effective Date January 1, 2010

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

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

2. By adding the following new definitions:

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

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

Routine patient care costs do not include:

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

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

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

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

(2) Severe food protein-induced enterocolitis syndromes;

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

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

A Prescription Order from your Health Care Practitioner is required.

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

1. By adding the following new sections:

Benefits for Routine Patient Costs for Participants in Certain Clinical Trials

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

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

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

Benefits for Early Detection Tests for Cardiovascular Disease

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

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

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

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

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

Preauthorization Requirements

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

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Contract. It ensures that the preauthorized care and services as described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. Preauthorization does not guarantee payment of benefits. However, coverage is always subject to other requirements of this Contract, such as Preexisting Conditions, limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

You, Your Physician, Provider of services, or a family member calls on of the toll-free numbers listed on the back of your Identification Card. The call should be made between 7:30 a.m. and 6:00 p.m. on business days. Calls made after working hours or on weekends will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. In most cases preauthorization is made within minutes while We are on the telephone with Your Provider's office.

Hospital Admissions

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

When a Hospital Admission is preauthorized, 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 preauthorized, Your Provider may request an extension for the additional inpatient days. If an admission extension is not preauthorized, benefits may be reduced or denied.

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

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

Failure to preauthorize 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.

Extended Care Expense and Home Infusion Therapy

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

Preauthorization for Extended Care Expense and Home Infusion Therapy must be obtained by having the agency or facility providing the services contact Us to request preauthorization. The request should be made:

- Prior to initiating Extended Care Expense or Home Infusion Therapy;

- When an extension of the initially preauthorized service is required; and
- When the treatment plan is altered.

If We have given notification that benefits for the treatment plan requested are not available, claims will be denied.

We will review the information submitted prior to the start of Extended Care Expense or Home Infusion Therapy. We will send a letter to You and the agency or facility confirming preauthorization or denying benefits.

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

Failure to preauthorize 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.

Organ and Tissue Transplants

Preauthorization is required for any organ or tissue transplant. Preauthorization 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. Preauthorization does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the preauthorized length of stay will not be denied on the basis of Medical Necessity or Experimental/Investigational.

At the time of preauthorization We will assign 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.

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 PPO Health Insurance Contract.

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

Review of Claim Determinations:

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

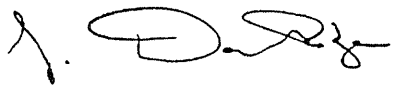
After processing the claim, We will determine and notify the Participant of the exact amount, if any, being paid on the claim; that the claim is being denied in whole or in part and the reason for denial; or that We require additional information before We can determine Our liability. If additional information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

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

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

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

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



President of Blue Cross and Blue Shield of Texas