BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.℠

Your Policy Book is Enclosed

BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.℠

Welcome to the Blue Cross and Blue Shield Difference… Health care benefits you can count on!

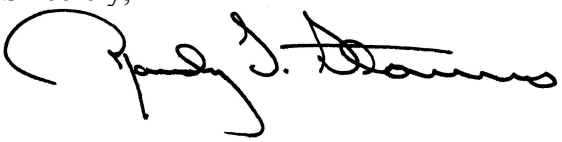
Dear DEBORAH J MYERS:

Thank you for choosing Blue Cross and Blue Shield of Texas (BCBSTX) to meet your unique health insurance coverage needs. By selecting Blue Cross and Blue Shield, you have chosen one of the most widely recognized names in health care.

Enclosed is your personalized Coverage Booklet, designed to help you take full advantage of your new SelecTEMP® PPO plan. Please review your booklet carefully, as it contains important details about your new coverage. You have 10 days from the date of delivery of this booklet to decide if it is right for you.

We look forward to having a long relationship with you, as well as an opportunity to provide service to you in the years to come. If you have any questions, please contact your health insurance agent or one of our knowledgeable Customer Service Advocates at 1-888-697-0683, Monday – Friday, 8 a.m. to 6 p.m., CT to assist you.

Sincerely,



Randy L. Starns
Director, Consumer Markets
Blue Cross Blue Shield Texas

Keep these documents in a safe place with your other important papers.

Thank you for choosing Blue Cross and Blue Shield!

"At a Glance" summary of your health insurance coverage

Identification Number:	0893149419
Coverage Effective Date:	12/02/2014
Benefit Period:	12/02/2014 through 11/02/2015
Original Premium Amount:	$404.00
Draft Day:	2

Approved applicants:

• DEBORAH J MYERS

Your satisfaction is guaranteed.

Once your coverage is in force, you have 10 days to decide if this policy is right for you. Please examine your policy carefully!

We're committed to you.

If you have any questions about any of the material in Your Coverage Booklet, or should there be a change of the policyholder's name, address or other information, please call your health insurance agent, or one of our Customer Service Advocates.

Medical: 1-888-697-0683
Monday - Friday, 8 a.m. - 6 p.m., CT

BlueCross BlueShield of Texas

Standard Authorization Form To Use or Disclose Protected Health Information (PHI)

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

Name _____ **Date of Birth** _____

Group # _____ **Identification/Subscriber #** _____ **Social Security Number** _____

Address _____ **City** _____ **State** _____ **ZIP** _____

Area Code & Telephone Number _____

II. Authorization and Purpose:

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

Persons/Organizations authorized to receive your information _____ **Relationship** _____ **Purpose** _____

Address _____ **City** _____ **State** _____ **ZIP** _____

III. Specific Description of Information to be Used or Disclosed *(Please Complete **Parts A and B** in this Section)*

This Authorization CANNOT be used to disclose Psychotherapy Notes.

A. Release of Sensitive Protected Health Information Under State Law

You must check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to ***(note: "yes" means this information is included in the categories you designate in Part B below)*** :

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

Yes ☐

No ☐

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

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

IV. Expiration and Revocation:

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

☐ 24 months 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 these 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 THIS FORM YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

(1) MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
(2) COMPLETING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Texas
P.O. Box 805107
Chicago, IL 60680-4112

If you need assistance completing the form, please refer to the instructions above or contact the Customer Service number listed on the back of your Member Identification Card.

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.

SCHEDULE OF COVERAGE
SELECTEMP® PPO-

SUBSCRIBER: **MYERS, DEBORAH J**

IDENTIFICATION NUMBER: **893149419**

EFFECTIVE DATE: **December 2, 2014**

BENEFIT PROVISIONS	NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Benefit Period Deductibles ▪ Individual ▪ Family	 $2,500 $7,500	 $5,000 $15,000
Coinsurance Amounts ▪ Individual ▪ Family	 $1,000 $3,000	 $3,000 $9,000
Lifetime Maximum	$2,000,000 each Participant	
Inpatient Hospital Expense	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Medical-Surgical Expense	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Physical Medicine Services	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
	$500 Benefit Period Maximum each Participant	
Ground and Air Ambulance Services	80% of Allowable Amount after Benefit Period Deductible up to $750 Benefit Period benefit maximum	
Routine Mammography Screening (For female Participants 35 years of age or older, limited to one each Benefit Period)	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Non-Routine Diagnostic Mammography	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Breast Reconstruction	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Tests for Detection of Human Papillomavirus and Cervical Cancer (For female Participants 18 years of age and older)	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Tests for Detection of Prostate Cancer	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Childhood Immunizations up to 8 years of age	100% of Allowable Amount No Deductible	
Hearing Screening (when offered by Hospital during a birth admission)	80% of Allowable Amount No Deductible	60% of Allowable Amount No Deductible
Tests for Detection of Colorectal Cancer	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible
Outpatient Contraceptive Services and Devices	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible

SCHEDULE OF COVERAGE
SELECTEMP® PPO-

BENEFIT PROVISIONS	NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Emergency – Accidental Injury/Medical		
▪ Emergency Room	80% of Allowable Amount after $100 Copayment Amount* and Benefit Period Deductible	
▪ Emergency Room Physician	80% of Allowable Amount after Benefit Period Deductible	
Non-Emergency Situations Facility and Physician Charges	80% of Allowable Amount after Benefit Period Deductible	60% of Allowable Amount after Benefit Period Deductible

*Waived if admitted to the Hospital immediately following visit

PRESCRIPTION DRUG PROGRAM			
PLAN FEATURES *Applicable to all Plans*			
Benefit Period Deductible	**$200**		
Benefit Period Maximum	**$750**		
Copayment Amounts	**Generic**	**Preferred Brand Name Drugs**	**Non-Preferred Brand Name Drugs**
Retail Pharmacy			
▪ 30-Day Supply on each occasion dispensed	$10	$40	$55
▪ 90-Day Supply	$30	$120	$165
Mail Service			
▪ 90-Day Supply	$20	$80	$110

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.*

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.

SelecTEMP® PPO
Temporary Individual Coverage

NOTICE

This Contract is subject to: (1) maximum lifetime benefits (2) termination of coverage in accordance with Article VI, and (3) preauthorization requirements.

NOTICE OF TEN-DAY RIGHT TO EXAMINE CONTRACT

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

SINGLE TERM NON-RENEWABLE SHORT TERM POLICY

Blue Cross and Blue Shield of Texas

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

Has issued this individual

PREFERRED PROVIDER CONTRACT

providing

Comprehensive Major Medical Expense Coverage

to

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

This Contract is effective from 12:01 a.m. on the Effective Date shown on the Identification Card and Schedule of Coverage and shall terminate at 11:59 a.m. on the expiration date shown on the Identification Card.

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

Non-Renewable: This Contract cannot be renewed and is therefore not intended to be a permanent plan. If You need coverage for an additional period of time, You may apply for a second Contract. Any condition which may have occurred under the prior Contract will be considered a Preexisting Condition under the subsequent Contract and will not be covered under the subsequent new Contract.

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

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

President of Blue Cross 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.

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Table of Contents

Article I — Definitions

As used in this Contract:

1. **Accidental Injury** means accidental bodily injuries sustained by a Participant which are the direct cause of the loss independent of disease, bodily infirmity, or any other cause.

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

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

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

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

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

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

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

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

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

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

5. **Benefit Period** means the period beginning on the Effective Date of this Contract and ending on the expiration date as specified on the Subscriber's Identification Card issued with this Contract.

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

7. **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).

8. **Coinsurance Amount** means the cumulative dollar amount of Eligible Expenses incurred by a Participant during a Benefit Period to be applied toward the Coinsurance Amount as described in the "**Coinsurance Amounts**" section in Article IV of this Contract.

9. **Complications of Pregnancy** means:

    a. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy including, but are 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; and

    b. 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.

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

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

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

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

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

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

    b. Is performed for psychological purposes; or

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

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

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

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

    c. For which a separate charge is customarily made;

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

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

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

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

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

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

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

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

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

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

g. A State health benefits risk pool;

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

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

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

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

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

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

b. Disability income coverage;

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

d. Coverage issued as a supplement to liability insurance;

e. Workers' compensation or similar coverage;

f. Automobile medical payment insurance;

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

h. Coverage for onsite medical clinics;

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

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

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

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

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

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

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

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

17. **Dependent** means:

    a. A Subscriber's spouse; or

    b. Any unmarried child who is at least 60 days' old and under 25 years of age.

    Child means:

    a. The natural child of the Subscriber; or

    b. 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

    c. A stepchild; or

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

    e. A grandchild of the Subscriber who is dependent upon the Subscriber for Federal income tax purposes at the time application for coverage is made.

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

    a. Diet;

    b. Regulation or management of diet; or

    c. The assessment or management of nutrition.

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

20. **Effective Date** means the date a Participant's coverage becomes effective under this Contract.

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

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

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

    b. Serious impairment to bodily functions,

    c. Serious dysfunction of any bodily organ or part,

    d. Serious disfigurement, or

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

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

    a. Controlled environment; or

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

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

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

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

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

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

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

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

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

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

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

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

    a. Health status;

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

    c. Claims experience;

    d. Receipt of health care;

    e. Medical history;

    f. Genetic information; and

    g. Disability.

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

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

    a. Drugs and IV solutions;

    b. Pharmacy compounding and dispensing services;

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

    d. Delivery services;

    e. Patient and family education;

    f. Nursing services.

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

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

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

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

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

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

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

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

    c. Has organized departments of medicine, diagnostic, major surgery (either on its premises or in facilities available to the Hospital on a contractual prearranged basis), and maintains clinical records on all patients;

    d. Is an institution which maintains and operates a minimum of five beds; and

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

    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.

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

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

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

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

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

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

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

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

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

38. **Legend Drugs** means drugs, 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.

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

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

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

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

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

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

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

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

Medical-Surgical Expense shall include:

a. Services of Physicians or Professional Other Providers.

b. Services of a certified registered nurse-anesthetist (CRNA).

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

d. Diagnostic x-ray and laboratory procedures.

e. Radiation therapy.

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

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

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

(2) Home air-fluidized bed therapy.

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

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

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

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

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

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

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

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

o. Services or supplies used by a Participant 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 the Prescription Drug Program.

q. Telehealth Services and Telemedicine Medical Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    b. Incision and drainage of facial abscess;

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

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

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

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

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

        (1) Durable Medical Equipment Provider
        (2) Home Infusion Therapy Provider
        (3) Imaging Center
        (4) Independent Laboratory
        (5) Prosthetic/Orthotics Provider
        (6) Renal Dialysis Center
        (7) Therapeutic Center

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

(1) Advanced Practice Nurse
(2) Doctor of Chiropractic
(3) Doctor of Dentistry
(4) Doctor of Optometry
(5) Doctor of Podiatry
(6) Doctor in Psychology
(7) Licensed Acupuncturist
(8) Licensed Audiologist
(9) Licensed Chemical Dependency Counselor
(10) Licensed Clinical Social Worker
(11) Licensed Dietitian
(12) Licensed Hearing Instrument Fitter and Dispenser
(13) Licensed Physical Therapist
(14) Licensed Professional Counselor
(15) Licensed Occupational Therapist
(16) Licensed Speech-Language Pathologist
(17) Marriage and Family Therapist
(18) Nurse First Assistant
(19) Physician Assistant
(20) Psychological Associate who practices solely under a Licensed Psychologist
(21) Surgical Assistant

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

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

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

57. **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.

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

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

60. **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.

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

62. **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*.

63. **Plan Service Area** means the Texas statewide geographical area.

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

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

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

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

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

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

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

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

70. **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.*

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

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

73. **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.

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

75. **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.

76. **Subscriber** means the person named on the Identification Card provided for this Contract.

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

    a. Compressed digital interactive video, audio, or data transmission;

    b. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and

    c. Other technology that facilitates access to health care services or medical specialty expertise.

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

    a. Compressed digital interactive video, audio or data transmission;

    b. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and

    c. Other technology that facilitates access to health care services or medical specialty expertise.

79. **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.

80. **You, Your, Yourself** means the person named on the Identification Card provided for this Contract.

Article II — Effective Date of Dependent Coverage

1. **Effective Dates**

Coverage under this Contract shall be contingent upon the Subscriber making application for such coverage on a form approved by Us. The application form must be submitted to Our Administrative Office in Richardson, Dallas County, Texas. Subject to Our approval of the application and payment of the required premium, coverage shall become effective at 12:01 a.m. on the later of:

a. The requested Effective Date; or

b. The day following the postmark date affixed by the U.S. Post Office.

If the envelope containing Your application for coverage is not postmarked by the U.S. Post Office, or if the postmark is not legible, the Effective Date will be the later of: (a) the requested Effective Date; or (b) the date We receive the application.

2. **Effective Date of a Dependent's Coverage**

Coverage under this Contract for a Dependent shall be contingent upon the Subscriber making application for such coverage on a form approved by Us. The application form must be submitted to Our Administrative Office in Richardson, Dallas County, Texas. Subject to Our approval of the application and payment of the required premium, coverage shall become effective as follows:

a. If a Dependent listed on the application is approved by Us at the same time as the Subscriber, coverage is effective on the Effective Date of this Contract.

b. Coverage for a Dependent of a Subscriber already having coverage under this Contract shall not be available. No one can be added to this Contract after the date of issue.

Article III — Payment of Benefits; Participant/Provider Relationship

1. **Payment of Benefits**

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

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

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

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

2. **Participant/Provider Relationship**

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

Article IV — Benefits Provided

1. **Medical Benefits**

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

a. **Preexisting Condition Exclusion**

Benefits are not available under this Contract for any services and supplies provided for a Preexisting Condition.

b. **Introduction**

We have established a network of Providers to serve Participants throughout Texas. By using Providers in the Network, You will maximize the benefits available to You under this Contract. You will receive a directory when You enroll listing Network Providers in Your Plan Service Area. An updated directory will be provided at least annually or You may access Out website at www.bcbstx.com for the most current listing to assist You in locating a Provider.

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

You, Your Physician, Provider of services, or a family member should preauthorize services when required by calling one of the toll-free telephone numbers listed on the back of Your Identification Card.

c. **How the Medical Plan Works**

(1) To receive Network Benefit under this Contract, 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 Network Provider has agreed to accept as payment in full the least of:

(a) The billed charges,

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

(c) Other contractually determined payment amounts,

and the Deductible, Copayment and Coinsurance Amounts You are responsible for paying. You are also responsible for any limited or non-covered services.

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

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

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

You will be responsible for billed charges above Our Allowable Amount, Coinsurance Amounts, and Deductibles, limited or non-covered services, preauthorization and any penalties for not preauthorizing care when required.

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

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

d. **Medical Necessity**

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

e. ***ParPlan* Providers**

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

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

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

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

f. **Preauthorization Requirements**

Preauthorization is required for all Hospital Admissions, and Home Infusion Therapy.

Preauthorization establishes in advance the Medical Necessity 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. 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 one of the toll-free numbers listed on the back of Your Identification Card. The call should be made between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central standard time on Saturday, Sunday, and legal holidays. Calls made after 6 p.m. central standard time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays will be recorded and returned the within 24 hours. 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.

(1) **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.

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 of Your claim.

(2) **Home Infusion Therapy**

Preauthorization is required for Medically Necessary Home Infusion Therapy.

Preauthorization for 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 the start of 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 Home Infusion Therapy. We will send a letter to You and the agency or facility confirming preauthorization or denying benefits.

If 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 Home Infusion Therapy.

g. **Copayment Amount and Deductible**

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

(1) ***Copayment Amounts***
A Copayment Amount is required for each emergency/treatment room visit as a result of Accidental Injury and Medical Emergency. The Copayment Amount is shown on Your Schedule of Coverage. *Eligible Expenses* for other covered charges provided at the time of the emergency/treatment room visit (e.g. facility and Physician charges and lab or x-ray will be subject to the Deductible and Coinsurance Amounts. The Copayment Amount will be waived if the Participant is admitted to the Hospital immediately following the visit.

(2) ***Deductibles***
The benefits of this Contract will be available after satisfaction of the Deductibles for Network and Out-of-Network Benefits as shown on Your Schedule of Coverage.

The Deductible will be subtracted once during each Benefit Period from the Participant's total combined *Inpatient Hospital Expense* and/or *Medical-Surgical Expense* incurred for that Benefit Period.

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

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

(c) When the total amount of the Deductible incurred in a Benefit Period by Participants under Your coverage equals three times the individual Deductible amount shown on Your Schedule of Coverage, all such Participants will have satisfied their Deductible for the remainder of that Benefit Period. No Participant will be allowed to contribute more than the individual Deductible amount to the family Deductible amount.

h. **Coinsurance Amounts**

(1) When a Participant's Coinsurance Amount during a Benefit Period 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 Benefit Period..

(2) When the total amount of the Coinsurance Amounts incurred in a Benefit Period by Participants under Your coverage equals the family Coinsurance Amounts shown on Your Schedule of Coverage, all such Participants will have satisfied their Coinsurance Amount for the remainder of that Benefit Period. No Participant will be allowed to contribute more than the individual Coinsurance Amount to the family Coinsurance Amount.

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

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

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

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

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

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

(d) The Copayment Amount for emergency room/treatment room visits; or

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

(f) Penalties for not preauthorizing *Inpatient Hospital Expense* or Home Infusion Therapy.

(g) Expenses in excess of our Allowable Amount determination.

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

i. **Maximum Benefits**

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

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

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

(4) All benefit payments made by BCBSTX for ***Benefits for Certain Therapies for Children with Developmental Delay,*** whether under the Network Benefits level or Out-of-Network Benefits level, will not apply toward the Calendar Year or lifetime benefit maximum under this Contract.

j. **Benefits for Inpatient Hospital Expense**

If *Inpatient Hospital Expense* is incurred during each Hospital Admission in excess of the applicable Deductible shown on Your Schedule of Coverage, benefits will be provided at 80% of the Allowable Amount for services received in a Network Hospital; or 60% of the Allowable Amount for services provided in an Out-of-Network Hospital.

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

If *Medical-Surgical Expense* is incurred by a Participant in excess of the applicable Deductible as shown on your Schedule of Coverage, benefits will be provided at 80% of the Allowable Amount for Network Benefits and 60% of the Allowable Amount for Out-of-Network Benefits. The remaining unpaid *Medical-Surgical Expense* in excess of the Deductible will be applied to the Coinsurance Amount.

l. **Case Management**

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

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

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

(2) The benefits are cost effective; and

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

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

m. **Special Benefit Provisions**

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

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

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

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

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

If a Participant incurs *Medical-Surgical Expense* for Physical Medicine Services, benefits will be provided on the same basis as any other sickness for Network Benefits and Out-of-Network Benefits up to a maximum benefit amount of $500 per Benefit Period for each Participant.

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

If *Medical-Surgical Expense* is incurred for professional local ground ambulance or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition, benefits will be provided at the Network Benefits level, up to a maximum benefit amount of $750 per Benefit Period for each Participant.

(4) ***Benefits for Routine Mammography Screening***

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

Benefits for ***non-routine*** mammography will be determined on the same basis as for any other *Medical-Surgical Expense* for Network Benefits and Out-of-Network Benefits

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

If a male Participant incurs *Medical-Surgical Expense* for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be determined at 80% of the Allowable Amount for Network Benefits; and 60% of the Allowable Amount for Out-of-Network Benefits. Benefits will be provided only for a:

- Physical examination for the detection of prostate cancer; and
- Prostate-specific antigen test used for the detection of prostate cancer for each male Participant under this Contract who is at least:

  (a) 50 years of age and asymptomatic; or

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

(6) ***Benefits for Certain Tests for Detection of Human Papillomavirus (HPV) and Cervical Cancer***
If a female Participant 18 years of age or older incurs Medical-Surgical Expense for an annual medically recognized diagnostic examination for the early detection of cervical cancer, benefits provided under this Contract shall include:

- A conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of hum Papillomavirus.

- Such screening test must be performed in accordance with the guidelines adopted by:
  (a) The American College of obstetricians and Gynecologists; or
  (b) Another similar national organization of medical professionals.

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

(a) Treatment provided for the correction of defects incurred in an Accidental Injury; or

(b) Treatment provided for reconstructive surgery following cancer surgery; or

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

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

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

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

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

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

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

(iii) The correction of damage caused solely by external, violent Accidental Injury to healthy, unrestored natural teeth and supporting tissues limited to such services and supplies provided:

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

b) To the termination date of this Contract,

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

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

(9) ***Benefits for Emergency Care***

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

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

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

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

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

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

(c) The Copayment Amount will be required for each outpatient Hospital emergency room visit as shown on Your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived.

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

Benefits for *Medical-Surgical Expense* incurred by a Dependent child up to age 8 for childhood immunizations will be determined at 100% of the Allowable Amount for Network and Out-of-Network Benefits. The Deductible, Coinsurance Amount, and Copayment Amounts, if any, will not be applicable.

Benefits are available for:

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

Allergy injections are not considered immunizations under this benefit provision.

(11) ***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 applicable Deductible will not apply. However, benefits will be subject to all other contractual provisions.

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

a. Diabetic Equipment

(1) Blood glucose monitors (including noninvasive glucose monitors and monitors designed to be used by the blind);

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

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

(3) Insulin infusion devices; and

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

b. Diabetic Supplies

(1) Test strips for blood glucose monitors,

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

(3) Lancets and lancet devices,

(4) Insulin and insulin analogs preparations,

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

(6) Biohazard disposable containers,

(7) Insulin syringes,

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

(9) Glucagon emergency kits.

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

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

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

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

(1) The physical cause and process of diabetes;

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

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

(4) Adjustment to lifestyle modifications; and

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

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

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

(13) ***Benefits for Acquired Brain Injury***

Benefits for Eligible Expenses incurred for Medically Necessary treatment of Acquired Brain Injury will be determined on the same basis as treatment for any other condition.

(a) Eligible Expenses include cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, or psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services, or community reintegration services necessary as a result of and related to an Acquired Brain Injury as defined in Article I, Section 2, of this Contract.

(b) For purposes of this benefit provision, the following definitions will apply:

- Cognitive communication therapy — Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

- Cognitive rehabilitation therapy — Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
- Community reintegration services — Services that facilitate the continuum of care as an affected individual transitions into the community.
- Neurobehavioral testing — An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
- Neurobehavioral treatment — Interventions that focus on behavior and the variables that control behavior and the variables that control behavior.
- Neurocognitive rehabilitation — Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- Neurocognitive therapy — Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- Neurofeedback therapy — Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- Neurophysiological testing — An evaluation of the functions of the nervous system.
- Neurophysiological treatment — Interventions that focus on the functions of the nervous system.
- Neuropsychological testing — The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- Neuropsychological treatment — Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- Psychophysiological testing — An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- Psychophysiological treatment — Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- Remediation — The process(es) of restoring or improving a specific function.
- Post-acute transition services — Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
- Services mean 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.

(14) ***Benefits for Certain Tests for Detection of Colorectal Cancer***

Benefits for *Medical-Surgical Expense* incurred for a diagnostic medically recognized screening examination for the detection of colorectal cancer for Participants 50 years of age or older and who are at normal risk for developing colon cancer are provided at 80% of the Allowable Amount after Benefit Period Deductible for Network Benefits; and 60% of the Allowable Amount after the Benefit Period Deductible for Out-of-Network Benefits. Such Participant shall be entitled to benefits for a:

(a) Fecal occult blood test performed annually and flexible sigmoidoscopy performed every five years; or
(b) Colonoscopy performed every ten years.

(15) ***Certain Therapies for Children with Development Delay***

a. *Medical-Surgical Expense* benefits are provided for a Dependent child under three years of age with developmental delay 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:

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

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

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

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

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

b. After the child has reached the age of 3, services under the *individualized family service plan* are completed and Eligible Expenses, as otherwise covered under this Contract, will be available. All contractual provisions of this Contract will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

2. Prescription Drug Program

a. Your Identification Card

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

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

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

Unauthorized, Fraudulent, Improper or Abusive Use of Identification Cards

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. How It Works

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

(1) ***Participating Pharmacy***
When You go to a Participating Pharmacy:

- present Your Identification Card to the pharmacist along with Your Prescription Order,
- provide the pharmacist with the birth date and relationship of the patient,
- sign the insurance claim log,
- pay the Pharmacy Deductible, if applicable, and

- pay the appropriate Copayment Amount for each Prescription Order filled or refilled and the pricing difference, if any.

Participating Pharmacies have agreed not to bill You for any covered prescription drug expenses in excess of the Pharmacy Deductible, if not previously satisfied, and Copayment Amount plus any pricing difference.

If You are unsure whether a pharmacy is a Participating Pharmacy, You may contact 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 Contract benefits.

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

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

(3) ***Mail Service Prescription Drug Program***

Your coverage provides a Mail Service Prescription Program to You and Your covered Dependents. The Prescription Drug Deductible, Prescription Drug Benefit Period Maximum, and Coinsurance Amount as shown on Your Schedule of Coverage will apply.

When You mail Your Prescription Orders to the address provided on the *Mail Service Prescription Drug Program Claim Form,* You must send in Your payment. If You need assistance in determining the amount of Your payment, You may either contact Customer Service at the telephone number shown on the back of Your Identification Card for assistance or send the amount of payment You determine will be needed.

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.

If You have any questions about the Program or need to obtain the *Mail Service Prescription Drug Program Claim Form,* You may access Our website at www.bcbstx.com or call the Customer Service at the telephone number shown on Your Identification Card.

(4) ***Maximum Prescription Drug Benefit***

The maximum amount of benefits available under the Program is $750 per Benefit Period for each Participant regardless of whether or not benefits are received at a Participating Pharmacy, or Non-Participating Pharmacy, or through the prescription drug mail service.

(5) ***Deductibles***

The $200 Pharmacy Deductible must be met by each Participant each Benefit Period. This Pharmacy Deductible will be applied to each Prescription Order filled or refilled until it is satisfied.

- If You use a Participating Pharmacy or the Prescription Drug Mail Service, the Pharmacy Deductible will be applied against the price of the drugs as agreed to by the Participating Pharmacy.
- If You use a Non-Participating Pharmacy, the Pharmacy Deductible will be applied against the retail cost of the drugs.

The pharmacist can tell You once the Pharmacy Deductible has been satisfied or You may contact the Customer Service Helpline.

After the Pharmacy Deductible is met, You will pay the appropriate Copayment Amount as described below.

(6) ***Copayment Amounts***
The Copayment Amounts applicable to Your coverage is 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 Prescription Drug Mail Service 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.

(7) ***Preferred Brand Name Drug List***
A Preferred Brand Name Drug List is a sample listing of the most commonly prescribed medications available in the Preferred Brand Name Drug category. This list does not include all of the Preferred Brand Name Drugs. If a medication is not on the Preferred Brand Name Drug List, You may call the Customer Service Helpline to find out which drugs are on the List and to determine Your benefit level.

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

(8) ***How Copayment Amounts Apply***
When Your Physician has marked the Prescription Order "Brand Necessary", the pharmacist may *only* dispense the brand name drug and You pay the appropriate Brand Name Copayment Amount.

If the Physician 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.

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

(10) ***Amount of Your Payment***
The amount of Your payment under the Program depends on whether:

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

(b) A Generic Drug or Brand Name Drug is dispensed.

c. **Limitations on Quantities Dispensed**

This Contract will pay for the dispensing of up to a 90-Day Supply of Covered Drugs on each occasion when You have a Prescription Order filled or refilled. The applicable Copayment Amount is shown on Your Schedule of Coverage.

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

Article V — Limitations and Exclusions

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

   a. Any services and supplies provided for a Preexisting Condition.

   b. Any services and supplies provided to any Participant 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 BCBSTX.

   e. Any services and supplies for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

   f. 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 shall not be applicable to any legislation, which specifies that the benefits of this Contract shall be deducted from the benefits available under such legislation.

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

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

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

   j. 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.

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

   l. 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.

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

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

o. Any services or supplies provided for Dietary and Nutritional Services, **except** for:

(1) An inpatient nutritional assessment program provided in and by a Hospital and approved by Us;

(2) ***Treatment of Diabetes***, and

(3) Dietary and nutritional evaluations provided in conjunction with ***Certain Therapies for Children with Developmental Delay***.

p. Any services or supplies for Custodial Care.

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

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

r. 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.

s. 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.

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

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

v. 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 Provision section in Article IV of this Contract.

w. Any services or supplies provided for mental, emotional or functional nervous disorders without demonstrable organic disease, except for Organic Brain Disease as defined in Article I of this Contract.

x. Except as specifically included as an Eligible Expense, any Medical Social Services; any outpatient family counseling and/or therapy, bereavement counseling, vocational counseling, or Marriage and Family Therapy and/or counseling.

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

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.

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 local ground ambulance service or air ambulance service otherwise covered hereunder.

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

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.

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 under the Prescription Drug Program, that are:

- Dispensed by a Pharmacy and received by the Participant while covered under this Contract,
- 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,
- Over-the-counter drugs and medicines; or drugs for which no charge is made,
- Prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations,
- Retin-A or pharmacological similar topical drugs, or
- Smoking cessation prescription drug products requiring a Prescription Order.

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

(1) ***Newborn Screening Tests for Hearing Impairment***, and

(2) ***Certain Tests for Children with Developmental Delay***.

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, Section 1m (12), of this Contract.

mm. Any services and supplies provided for skilled nursing care, Hospice Care, or Home Health Care.

nn. Any services and supplies provided for organ and tissue transplants.

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

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

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

b. Devices or durable medical equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, prescription 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 Contract.

c. Administration or injection of any drugs.

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

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

f. Any services and supplies for which benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

g. 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 shall not be applicable to any coverage held by the Participant for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

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

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

j. Infertility medication and fertility medication; 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 Contract.

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

l. 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.

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

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

o. 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.

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

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 Contract, 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. Any smoking cessation products requiring a Prescription Order.

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).

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

Article VI — Termination of Coverage

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

   a. On the last day of the last period for which the premium for this Contract has been paid to Us, subject to the Grace Period provided in Article VII, Section 4; or

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

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

   d. On the date the Contract benefit maximum is reached; or

   e. On the expiration date as shown on the Subscriber's Identification Card; provided, however, coverage for any continuous illness or injury that began while this Contract is in force shall continue during the continuous Total Disability of the Participant until the earliest of:

      (1) The date the Participant is no longer Totally Disabled, or
      (2) Payment of maximum benefits under this Contract, or
      (3) The end of 90 days.

      Total Disability, for purposes of this Subsection e, means the complete inability of a Participant as a result of injury or sickness to engage in any employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience, such individual is not in fact engaged in any employment or occupation for wage or profit, and is confined as a bed patient in a Hospital or Facility Other Provider.

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

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

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

      (2) Coverage for any unmarried child who is medically certified as Disabled and dependent upon You shall not terminate upon reaching age 25 if the child continues to be both: (a) Disabled, and (b) chiefly dependent upon 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 Contract and before the child attains 25. You must submit satisfactory proof of the disability and dependency

to Us within 31 days following the child's attainment of age 25. As a condition to the continued coverage of a child as a disabled Dependent beyond age 25, We may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two-year period following the child's attainment of age 25.

b. On the date of death of the Dependent.

3. Notwithstanding the provisions of Section 1 and 2 above, pursuant to the Soldiers' and Sailor's Civil Relief Act of 1940 ("SSCRA"), within 30 days of receipt of a written request by the Subscriber to suspend the Subscriber's and/or Dependents' coverage under this Contract due to active military duty, any premium paid beyond the day such service commenced shall be refunded on a pro rata basis. If any claims were paid during the period of active duty, refunds will be requested.

Article VII — Standard Provisions

1. **Change of Beneficiary:** The right to change a beneficiary is reserved for the insured, 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.

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

3. **Contract; Amendments:**

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

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

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

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

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

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

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

9. **Proof of Loss:**

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

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

    This Contract will remain contestable as long as it is in force. Any misstatements or omissions made in Your application for coverage shall be used to void coverage or to deny a claim for benefits on account of hospitalization or medical-surgical services provided during the term of this Contract.

11. **Rescission of Coverage**: Any omission of a material fact, or fraudulent misstatements, or intentional misrepresentation of a material fact on the Subscriber's application will result in the cancellation of Your coverage (and/or Your Dependent(s)) coverage retroactive to the Effective Date. In the event of such cancellation, Blue Cross and Blue Shield of Texas 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 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.

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

Article VIII — General Provisions

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

2. **Disclosure Authorization:**

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

   b. As a condition to the continued coverage of a child as a disabled Dependent beyond the age of 25, We shall have the right to require periodic certification of the child's physical or mental condition and dependency, but not more frequently than annually after the two-year period following the child's attainment of age 25.

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

4. **Non-Agency:** You understand that this Contract constitutes a contract solely between You and Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX is 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. You also understand that You have not entered into this Contract based upon representations by any person other than BCBSTX. No person, entity, or organization other than BCBSTX shall be held accountable or liable to You for any of its obligations created under this Contract. This Section 4 shall not create any additional obligations whatsoever on the part BCBSTX other than those obligations created under other provisions of this Contract.

5. **Premiums:**

   The premium applicable to this Contract is determined by You, Your age, Your place of residence on each premium due date, certain health conditions or a combination of such health conditions, including but not 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, Your premium will be based on the age of each adult.

   To notify Us of any change in Your place of residence, You may notify Us in writing or You may call Our Customer Service department within 30 days of the date of the change.

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

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

7. **Review of Claim Determinations:**

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

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

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

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

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

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

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

8. **State Government Programs:**

a. Benefits for services or supplies under this Contract shall not be excluded solely because benefits are paid or payable for such services or supplies under a state plan for medical assistance (Medicaid) made pursuant to 42 U.S.C., Section 1346 et seq., as amended. Any benefits payable under such state plan for medical assistance shall be payable to the Texas Department of Human Services to the extent required by Article 21.4910 of the *Texas Insurance Code*.

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

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

(2) The parent who is covered by this Contract has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support; and

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

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

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

Right of Reimbursement

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

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

Right to Recovery by Subrogation or Reimbursement

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

Amendments

An Amendment

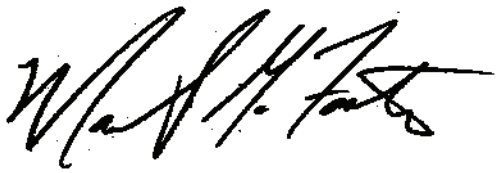
Effective December 1, 2007

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

Your Contract is amended as follows:

ARTICLE VII – STANDARD PROVISIONS of Your Contract is amended by deleting the following provision:

Change of Beneficiary: The right to change a beneficiary is reserved for the insured, 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.



President of Blue Cross Blue Shield of Texas

An Amendment

Effective Date January 1, 2008

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

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

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

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

- Remediation — The process(es) of restoring or improving a specific function.
- Post-acute transition services — Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration, including outpatient day treatment or other post-acute care treatment. This shall include coverage for reasonable expenses related to periodic reevaluation of the care of an individual covered under this plan who:

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

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

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

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

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

President of Blue Cross and Blue Shield of Texas

An Amendment

Effective Date January 1, 2008

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

The Front Page of Your Contract is amended by deleting the wording of the fourth paragraph in its entirety and substituting the following:

This Contract is effective from 12:01 a.m. on the Effective Date shown on the Identification Card and Schedule of Coverage and shall terminate at 11:59 p.m. on the expiration date shown on the Identification Card.

President of Blue Cross and Blue Shield of Texas

An Amendment

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

Your Contract is amended as follows:

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

   Use of Non-Contracting Providers

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

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

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

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

   - ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with BCBSTX in Texas or any other Blue Cross and Blue Shield Plan outside of Texas (non-contracting Allowable Amount)* –** The Allowable Amount will be the lesser of the Provider's billed charges or the BCBSTX non-contracting Allowable Amount. The non-contracting Allowable Amount is developed using BCBSTX network Allowable Amount data for similar Network Providers at a service level identified by standard contracting identification methods. The Allowable Amount for non-contracting Providers represents the average contract rate for Network Providers adjusted by a predetermined factor established by BCBSTX and updated on a periodic basis. Such factor shall not be less than 75 % and will be updated not less frequently than once every two years. The non-contracting Allowable Amount does not equate to the Provider's billed charges and

Participants receiving services from a non-contracting Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracting Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Participants may call customer service at the number on the back your BCBSTX Identification Card.

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

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

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

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

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

An Amendment

Effective Date January 1, 2010

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

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

1. 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, and Home Infusion Therapy.

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 benefi**ts**. 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 one of the toll-free numbers listed on the back of Your Identification Card. The call should be made between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central standard time on Saturday, Sunday, and legal holidays. Calls made after 6 p.m. central standard time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays will be recorded and returned the within 24 hours. 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.

Home Infusion Therapy

Preauthorization is required for Medically Necessary Home Infusion Therapy.

Preauthorization for 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 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 Home Infusion Therapy. We will send a letter to You and the agency or facility confirming preauthorization or denying benefits.

If 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 Home Infusion Therapy.

The LIMITATIONS AND EXCLUSIONS Section of Your Contract is amended by deleting the exclusion regarding "Fluids, solutions, nutrients, or medications" in its' entirety and substituting the following:

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

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

Review of Claim Determinations:

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

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

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

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

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

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

President of Blue Cross and Blue Shield of Texas

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 CONTRACTHOLDER

BlueCard

Like all Blue Cross and Blue Shield Licensees, the Plan participates in a program called "BlueCard." Whenever Participants access health care services outside the Plan's service area, the claims for those services may be processed through BlueCard and presented to the Plan for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Participants receive covered services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), the Plan will remain responsible to the Contractholder for fulfilling the Plan's contract obligations.

However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers, handling all interaction with its participating Providers. The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim

The calculation of the Participant's liability on claims for covered services incurred outside the Plan's service area and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price the Plan pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by the Plan on a claim for health care services processed through BlueCard may represent:

(i) The actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"), or

(ii) An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or

(iii) An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Participant and the Contractholder from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or an Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over– or underestimation of past prices. However, the amount paid by the Participant is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating the Participant's liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate the Participant's liability for any covered services consistent with the applicable state statute in effect at the time the Participant received those covered services.

Return of Overpayments

Under BlueCard, recoveries from a Host Blue or from participating Providers of a Host Blue can arise in several ways, including but not limited to anti-fraud and abuse audits, Provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis.

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** 60% 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	$2,700
Your Coinsurance Amount	$950	$1,800
Non-Contracting Provider's additional charge to you	None	$15,000[1]
YOUR TOTAL PAYMENT	**$1,200 to a Network Provider**	**$17,300 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

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.

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

31025.1108 TX

Questions?

For questions call:

Service	Numbers to Remember
Benefits/Enrollment Information	(800) 531-4456 Toll-free (972) 766-5218 Central time Hours: 9 a.m. to 5 p.m., Monday-Thursday; 9 a.m. to 4:30 p.m., Friday OR Your Local Insurance Agent
How to Find a BlueChoice® Network Provider	(800) 521-2227 Toll-free Hours: 8 a.m. to 8 p.m., Monday-Friday
Customer Service, Benefits or Claims Questions	(888) 697-0683 Toll-free Hours: 8 a.m. to 8 p.m., Monday-Friday
Visit our Web site	www.bcbstx.com

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

BlueCross BlueShield of Texas

Experience. Wellness. Everywhere.®'

www.bcbstx.com

45898.0510
SelecTEMP PPO Contract

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

An Amendment

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

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

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

   Allowable Amount

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

An Amendment

Effective Date 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:

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

BlueCross BlueShield of Texas

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how Blue Cross and Blue Shield of Texas can use or disclose your medical information and how you can get access to this information. Our contact information can be found at the end of the notice. **Please review this notice carefully.**

YOUR RIGHTS. When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	* You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this by using the contact information at the end of this notice. * We will provide a copy or a summary of your health and claims records usually within 30 days of the request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	* You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this by using the contact information at the end of this notice. * We may say "no" to your request. We'll tell you why in writing within 60 days.
Request confidential communications	* You can ask us to contact you in a specific way or to send mail to a different address Ask us how to do this by using the contact information at the end of this notice. * We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	* You can ask us **not** to share or use certain health information for treatment, payment or our operations. Ask how to do this by using the contact information at the end of this notice. * We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	* You can ask for a list (accounting) for six years prior to your request date of when we shared your information, who we shared it with and why. Ask us how to do this by using the contact information at the end of this notice. * We will include all the disclosures except for those about treatment, payment, and our operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but we may charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this notice	* You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. To request a copy of this notice, use the contact information at the end of this notice and we will send you one promptly.
Choose someone to act for you	* If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Ask us how to do this by using the contact information at the end of this notice. * We confirm the person has the authority and can act for you before we share your information.

YOUR RIGHTS (continued)

File a complaint if you feel your rights are violated	* You can complain if you feel we have violated your privacy rights by using the contact information at the end of this notice. * You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or by sending a letter to them at: 200 Independence Ave., SW, Washington, D.C. 20201. * We will not retaliate against you for filing a complaint.

YOUR CHOICES. For certain health information, you can tell us your choices about what we share.

If you have a clear preference on how you want us to share your information in the situations described below, tell us and we will follow your instructions. Use the contact information at the end of this notice.

In these cases, you have both the right and choice to tell us to:	* Share information with your family, close friends, or others involved in payment for your care * Share information in a disaster or relief situation * Contact you for fundraising efforts

If you cannot share your preference, for example, if you are unconscious, we can share your information if we think it is in your best interest. We may share information when needed to lessen a serious or imminent threat to health or safety.

We *never share your* information in these situations unless you give us written permission	* Marketing purposes * Sale of your information

OUR USES AND DISCLOSURES. How do we use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	* We can use your health information and share it with professionals who are are treating you.	* *Example: A doctor sends us information about our diagnosis and treatment plan so we can arrange additional services.*
Run our organization	* We can use and disclose your information to run our organization and contact you when necessary.	* *Example: We use health information to develop better services for you.*

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. *This does not apply to long-term care plans.*

Pay for your health services	* We can use and disclose your health information since we pay for your health services.	* *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan	* We may disclose your health information to your health plan sponsor for plan administration purposes.	**Example: If your company contracts with us to provide a health plan, we may provide them certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information go to: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	* We can share your health information for certain situations such as: * Preventing disease * Helping with product recalls * Reporting adverse reactions to medications * Reporting suspected abuse, neglect or domestic violence * Preventing or reducing a serious threat to anyone's health or safety
Do research	* We can use or share your information for health research.
Comply with the law	* We will share information about you when state or federal law requires it, including the Department of Health and Human Services if they want to determine that we are complying with federal privacy laws.
Respond to organ/tissue donation requests and work with certain professionals	* We can share health information about you with an organ procurement organization. * We can share information with a medical examiner, coroner or funeral director.
Address workers' compensation, law enforcement, and other government requests	* We can use or share health information about you: * For workers' compensation claims * For law enforcement purposes or with a law enforcement official * With health oversight agencies for activities authorized by law * For special government functions such as military, national security, and presidential protective services or with prisons regarding inmates.
Respond to lawsuits and legal actions	* We can share health information about you in response to an administrative or court order, or in response to a subpoena.
Certain health information	* State law may provide additional protection on some specific medical conditions or health information. For example, these laws may prohibit us from disclosing or using information related to HIV/AIDS, mental health, alcohol or substance abuse and genetic information without your authorization. In these situations, we will follow the requirements of the state law.

OUR RESPONSIBILITIES. When it comes to your information, we have certain responsibilities.

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that compromises the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing.

You may change your mind at any time. Let us know in writing if you change your mind.

For more information: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes we make will apply to all information we have about you. The new notice will be available upon request or from our website. We will also mail a copy of the new notice to you if there are material changes to our privacy practices.

CONTACT INFORMATION

If you would like general information about your privacy rights or would like a copy of this notice, go to: http://www.bcbstx.com/important_info/index.html. If you have specific questions about your rights or about this notice, you may contact us in one of the following ways:

* Call us at the toll-free number on the back of your member identification card.
* Call us at 1-877-361-7594.
* Write us at:

Divisional Vice President, Privacy Office
Blue Cross and Blue Shield of Texas
P.O. Box 804836
Chicago, IL 60680-4110

EFFECTIVE DATE OF THIS NOTICE

September 23, 2013

BlueCross BlueShield of Texas

P.O. Box 3236, Naperville, IL 60566-7236
(888) 697-0683

SelecTEMP® PPO

Temporary Individual Coverage

Application for Comprehensive Major Medical Insurance
Please Print all information in blue or black ink.

Home office use only

Requested Effective Date 12/02/2014 (MM/DD/YY)

Your Information

Applicant's First Name, M.I., Last Name	Sex	Birth Date	Age	Social Security Number
Deborah J Myers	F	05/24/1951	63	

Street Address	City	State	ZIP Code
16527 Town Lake Court	Houston	TX	77059

Home Telephone Number	Work Telephone Number
(972) 978-9109	

Dependents to be Covered (First Name, M.I., Last Name)	Sex	Birth Date	Age	Social Security Number

Children you wish to cover must be unmarried, at least 60 days of age, and less than 25 years of age.

Plan Selection and Benefit Period – Which plan would you like to select and for how long?

I (we) hereby apply for:

Benefit Period:
☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months
☐ 7 months ☐ 8 months ☐ 9 months ☐ 10 months ☑ 11 months

Deductible Amount:
☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☑ $2,500

Total Premium Due $ 404.00

Make your check payable to **Blue Cross and Blue Shield of Texas**. Processing will be delayed or applicant will be withdrawn if appropriate premium is not received with your application.

Method of Payment – Which method of payment do you prefer?

☐ Single Payment Plan — Available for 1-11 month benefit periods. The entire premium must be submitted with the application.

☑ Monthly Bank Draft — Available for 2-11 month benefit periods. The first month of premium must be submitted with the application along with a completed Bank Draft Authorization Request Form and a blank check marked "VOID."

Are you or any person to be insured a U.S. citizen or a permanent resident living in the United States for at least 2 years? ☑ Yes ☐ No
If the answer is "No" the coverage cannot be issued.

Health Information – Tell us about yourself.

If the answer is "Yes" to any of the following questions, this coverage cannot be issued.

1. Is any female to be covered now pregnant **or** is any male to be covered an expectant parent? ☐ Yes ☑ No
2. In the past five years, has any person applying for coverage been advised, consulted, tested, diagnosed, treated, hospitalized, taken medication for, or been recommended for treatment for any of the following: heart or circulatory system disorder, including heart attack or stroke; diabetes; cancer or tumors; disorder of the blood; kidney or liver disorder; mental or nervous conditions or disorders; alcoholism or alcohol abuse; drug abuse, addiction or dependency; organ transplant? ☐ Yes ☑ No
3. Has any person applying for coverage been diagnosed by a member of the medical profession as having acquired immune deficiency syndrome (AIDS) or AIDS-related complex; or has any person applying for coverage in the past five years tested positive for HIV virus (ELISA or Western Blot)? ☐ Yes ☑ No
4. Do you or any person named on this application plan on participating in motor vehicle or boat racing; mountain climbing; bungee jumping; hang gliding or sky diving during this coverage? ☐ Yes ☑ No
5. Do you or anyone else who will be insured by this contract plan to reside outside of Texas during this coverage? ☐ Yes ☑ No

Acknowledgment: I have read this application and to the best of my knowledge, the statements and answers are true and complete. I understand that fraud or any intentional misrepresentation of a material fact may result in the loss of coverage under this contract. I also understand that: 1) Blue Cross and Blue Shield of Texas will provide no coverage until my application is accepted and the correct premium is received by Blue Cross and Blue Shield of Texas; 2) this contract will pay no benefits for any illness, accident or physical impairments which existed or occurred within two years prior to the effective date; 3) if the contract is issued, it will not be a continuation of any previous medical plan, including any prior short term coverage; **4) if my completed application is approved, the coverage will take effect on the later of: (a) the requested effective date; or (b) the day after the postmark date affixed by the U.S. Postal Office. If the envelope containing the application is not postmarked, or the postmark is not legible, the effective date will be the later of: (a) the requested effective date; or (b) the date the completed application is received by Blue Cross and Blue Shield of Texas.**

Health Authorization: I authorize any hospital, physician, provider, clinic or medical related facility, governmental agency, insurance carrier, group health plan or other entity to give Blue Cross and Blue Shield of Texas (BCBSTX) the Company or its authorized representative, upon request, any information concerning the health condition of any person listed on this application whenever such information is considered necessary by the Company for the proper disposition of this application.

I understand that this authorization is voluntary and that my signature is required for the Company to consider this application and to make a determination on whether to accept and issue the coverage applied for herein and that without my signed authorization no action will be taken on this application. I also understand that I may revoke this authorization at any time in writing and that such revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I further understand the potential that any information disclosed pursuant to this authorization may be redisclosed and is no longer protected by the Federal privacy laws. A photographic copy of this authorization shall be as valid as the original.

The undersigned Applicant further acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if **he/she desires** additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, they should contact the agent.

Applicant's Signature (If Applicant is under the age of 18, parent or guardian's signature)	Date
Deborah J Myers (E-Authorization)	12/01/2014
Spouse's Signature	Date
Dependent's Signature (age 18 and over)	Date

Agency Name	Agent Address	City	State	ZIP Code	(Area Code) FAX Number
	PO BOX 58898	Webster	TX	77598	

Agent Name	Agent Number	Signature	(Area Code) Telephone Number	Date
MARY LADMIRAULT	000012269	MARY LADMIRAULT (E-Authorization)	2813334829	12/01/2014

Automatic Premium Payment Authorization Agreement

BlueCross BlueShield of Texas

Take these simple steps for hassle-free monthly premium payments:

- Verify with your financial institution that they can accept automated electronic withdrawals.
- Complete, sign and return this authorization form.
- If submitting by fax, please fax this form toll-free to: (888) 697-0686
- If submitting by mail, please send to:

  Blue Cross and Blue Shield of Texas
  P.O. Box 3236
  Naperville, IL 60566-7236

If you have any questions about this program, please call our Customer Service Department toll-free at (888) 697-0683.

AGREEMENT

I request and authorize Blue Cross and Blue Shield of Texas (BCBSTX) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. As the account holder, by signing below, I also certify, in the event that this draft is being drawn from a company checking account, that I am authorized to approve this transaction, that the company is not paying any portion of the premium for this subscriber, either directly, or through reimbursement, and that the employer/company is not deducting any part of the premium from gross income under section 106 or section 162 of the Internal Revenue Code. I understand that both the financial institution and BCBSTX reserve the right to terminate this payment program and/or my participation therein. I also understand that I may discontinue this payment program at any time with at least 10 days advance notice to Blue Cross and Blue Shield of Texas by telephone prior to a scheduled withdrawal date.

Please complete the following ~ Print or Type information

☑ **Yes** ☐ **No** Deduct ongoing monthly premium payments from my designated checking or savings account. Drafts will be drawn on the preferred draft day specified below (does not apply to SelecTEMP PPO). For SelecTEMP PPO and when a preferred draft day is not specified for other products, drafts will be drawn on the premium due date. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day. (Please note that coverage cannot be issued until the first month of premium has been received in our office, unless you have authorized Blue Cross and Blue Shield of Texas to deduct the initial payment upon receipt of your application.)

☐ **Yes** ☑ **No** Please deduct a $30.00 Non-Refundable application fee from my checking account **upon receipt of my application** for permanent coverage. The application will not be processed without the non-refundable application fee.

☑ **Yes** ☐ **No** Upon receipt of my application, deduct the initial premium payment from my checking or savings account.

01 **Preferred Draft Day**. It must be on or prior to the premium due day. If the selected preferred draft day falls after the premium due day, the monthly premium will be drawn on the day premium is due. (Cannot be the 29th, 30th or 31st.)

☐ **Yes** ☑ **No** For SelecTemp PPO applicants only: upon receipt and approval of my SelecTEMP PPO application, please deduct the premiums due for the designated benefit period.

Policy Identification Number/Applicant's Social Security Number: _____

Please check one: ☑ Checking Account ☐ Savings Account

Name of applicant/member: **Deborah J Myers**

Name of depositor(s) if other than the applicant: _____

Name of bank where account is authorized: **Wells Fargo**

Address of bank: **2323 Clear Lake City Blvd, Houston, TX, 77062**

Bank transit number: **111900659**

Depositor's account number: **9824009282**

Memo _____

I: 184002763 I: 14570720 I I•

↑ Bank Transit Number ↑ Depositor's Account

I have read and accept the above agreement.

Depositor's signature: **Deborah J Myers (E-Authorization)** Date: **12/01/2014**

Blue Cross and Blue Shield of Texas Receipt

A Blue Cross and Blue Shield of Texas Customer Service Representative will review your application. You will be notified regarding the progress of your application via e-mail at the following address: debbie6303@yahoo.com. You can log in to check the status of your application at https://retailweb.hcsc.net/retailshoppingcart/TX/account?source=AAAAAAAAA0. If you have any questions please contact us toll-free at 1-888-672-2583.

Thanks for your application!

Blue Cross and Blue Shield of Texas
P.O. Box 3236
Naperville, IL 60566-7236
1-888-672-2583

Application For
Deborah J Myers

Coverage Selected: SelectTemp PPO (7-11 month coverage)
Deductible: $2,500.00
Total: $404.00

Application Number: 0003769900
Trace Number: TXW0003769900

The information above was provided by the account holder via the internet.
Credit card transactions should appear on your next account statement.

Acceptance of your payment does not guarantee coverage. Your application will be reviewed by underwriting. If not approved, any premium you pay will be refunded.

Frequently Asked Questions

Please read below, and if further clarification is needed, call us toll-free Monday-Friday, 8 a.m. - 6 p.m., CT at 1-888-697-0683. We are here to help you!

How do I make changes to my policy, plan or personal information?

Please keep us informed of changes to your name, phone number, address or billing information by calling our Customer Service Advocates. If you would like to make any other changes to your policy, such as changing your plan, deductible or adding dependents, we will be happy to discuss those options with you. Please note that some of these changes may require a written request, and others may impact your premium amount.

Our Customer Service Advocates can help with any questions that you have, or any changes that you wish to make. Simply call us at 1-888-697-0683 and we will be happy to assist you!

Do I have coverage when I'm traveling out of state, or outside the U.S.?

The PPO "suitcase" logo PPO on your Blue Cross and Blue Shield of Texas (BCBSTX) ID card indicates that you are part of the BlueCard PPO program. You can be linked through the BlueCard PPO program and use your coverage across the country and around the world utilizing a network of providers. Always carry your BCBSTX ID card as it contains helpful information for accessing health care when you are away from home. If you do not see this logo PPO on your BCBSTX ID card, please call the customer service number on the back of your ID card to learn more about your coverage while traveling.

May I purchase another temporary policy when mine expires?

Our temporary coverage is a short-term limited duration policy that is non-renewable. However, if coverage is needed for an additional period of time, you may purchase a second consecutive policy, subject to meeting eligibility requirements. If a second temporary policy is purchased, a new deductible(s) must be met and, to avoid a break in coverage, your application must be received prior to cancellation of the first SelecTEMP PPO policy. Please also note that any condition that may have existed or occurred under the prior temporary policy will be considered a Pre-Existing Condition under the subsequent policy and will not be a covered benefit.

To learn about available permanent policy options, please contact your agent or call a helpful member of our sales staff at 1-800-531-4456.

May I cancel my coverage before my temporary policy benefit period ends?

If your temporary policy covers a multi-month benefit period, and you no longer need coverage, you may cancel your policy as of the next monthly billing period. If you paid all of the premium up front, or you pay via bank draft and cancel too close to your next draft day, BCBSTX will issue you a refund of your pre-paid premiums for the cancelled months.

If you are covered under a temporary benefit plan, and are then issued coverage under a new individual major medical BCBSTX plan, your temporary coverage is cancelled automatically upon issuance of the new plan. For your convenience, no signature will be required to transfer funds from the temporary policy to the new plan. Please refer to your policy book included in this booklet for more information, or feel free to call us as well!

BlueCross BlueShield of Texas
Experience. Wellness. Everywhere.℠
P.O. Box 3236 • Naperville, Illinois 60566-7236

Address Service Requested

DEBORAH J MYERS
16527 TOWN LAKE COURT
HOUSTON, TX 77059

Any Questions?

Call us toll-free at 1-888-697-0683, Monday - Friday, 8 a.m. - 6 p.m., CT, or log on at *www.bcbstx.com*.

52106.0210TX