POLICYHOLDER:	Baylor University
POLICYNUMBER:	078152 ("the Policy")
EFFECTIVEDATE:	August 1, 2019
POLICYTERM:	August 1, 2019 through July 31, 2020
PREMIUM DUE DATE:	On or before August 1, 2019 ("Policy Effective Date")

This Policy describes the terms and conditions of coverage as issued to the Policyholder named above. The Policy is issued in the state of Texas and is governed by its laws. The Policy becomes effective at 12:00 A.M. on the Policy Effective Date at the Policyholder's address.

Blue Cross and Blue Shield of Texas ("BCBSTX"), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (the "Insurer") and the Policyholder have agreed to all of the terms of the Policy as stated herein.

Policyholder has confirmed to Insurer that it is an institution of higher education as defined in the Higher Education Act of 1965. This Policy does not make health insurance available other than in connection with enrollment as a Student (or a Dependent of a Student) in the Policyholder's Institution. If Covered Persons have any questions once they have read this Policy, they can call Us at 1-855-267-0214. It is important to all of Us that Covered Persons understand the protection this coverage gives them.

Signed for Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company by:

Jeffrey R. Tikkanen, President of Retail Markets
Blue Cross and Blue Shield of Texas
1001 E. Lookout Drive Richardson, TX 75082

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE PLEASE READ THIS POLICY CAREFULLY

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

Notice

Please note that Blue Cross and Blue Shield of Texas has contracts with many health care Providers that provide for Us to receive, and keep for Our own account, payments, discounts and/or allowances with respect to the bill for services the Covered Person receives from those Providers.

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health benefit plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his/her own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care Providers and particular benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular benefit plan.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED

The Covered Person should be aware that when the Covered Person elects to utilize the services of an Out-of-Network Provider for treatment, services, and supplies not excluded or limited by the Policy in non-emergency situations, benefit payments to such Out-of-Network Providers are not based upon the amount billed. The basis of the Covered Person's benefit payment will be determined according to the Covered Person's Policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the Policy. THE COVERED PERSON CAN EXPECT TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Out-of-Network Providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the member other than applicable Copayments, Coinsurance and Deductible amounts. The Covered Person may obtain further information about the participating status of Providers and information on Out-of-Pocket Maximums by calling the toll-free telephone number on the Covered Person's identification card. For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Texas Customer Service at 1-855-267-0214. Should the Covered Person wish to know the Allowable Amount for a particular health care service or procedure or whether a particular Provider is a Network Provider or an Out-of-Network Provider, contact the Covered Person's Provider or Blue Cross and Blue Shield of Texas. Should the Covered Person wish to know the estimated Claim Charge for a particular health care service or procedure, please contact the Covered Person's Provider.

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-654-9390

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

Blue Cross and Blue Shield of Texas
1001 E. Lookout Drive
Richardson, TX 75082

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:

The Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 490-1007
Web: 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 información o para presentar una queja:

Usted puede llamar al número de teléfono gratuito de Blue Cross and Blue Shield of Texas para obtener información o para presentar una queja al:

1-800-654-9390

Usted también puede escribir a Blue Cross and Blue Shield of Texas:

Blue Cross and Blue Shield of Texas
1001 E. Lookout Drive
Richardson, TX 75082

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener información sobre compañías, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

El Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 490-1007
Sitio web: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamación, usted debe comunicarse con la compañia primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU PÓLIZA:

Este aviso es solamente para propósitos informativos y no se convierte en parte o en condición del documento adjunto.

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Eligibility for Insurance

Each person in one of the Class(es) of Eligible Persons shown below is eligible to be insured under this Policy. This includes anyone who is eligible on the Policy Effective Date, and may become eligible after the Policy Effective Date while the Policy is in force. Students must actively attend class for the number of days as listed on the Schedule of Benefits. Home study, correspondence, on-line, and television (TV) courses do not fulfill the eligibility requirements. We maintain the right to investigate student status and attendance records to verify that eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any premium paid for that person.

CLASSES OF ELIGIBLE PERSONS:

Class I: All registered Domestic students taking six (6) or more credit hours three (3) or more credit hours in the summer are eligible to enroll in the insurance plan.

Class II: Graduate students taking one (1) or more credit hours, students participating in an internship, and students enrolled in the master or doctoral level thesis or dissertation class, and all other graduates students taking six (6) or more credit hours, are eligible to enroll in the insurance plan.

Class III: Law students taking one (1) or more credit hours are eligible to enroll in the insurance plan.

Class IV: Domestic, Graduate and Law students may complete the enrollment form or enroll online.

Class V: All registered International students on non-immigrant visas, taking one (1) or more credit hours are required to participate in the Baylor University Student Health Insurance Plan. Although students are welcome to submit an application for a waiver, in order to have such waiver approved, the plan submitted must be equivalent to the University Student Health Insurance Plan in all material respects.

Class VI: All J Scholars and students on campus for Academic Research or Study are required to participate in the Baylor University Student Health Insurance Plan.

NOTE: Multiple classes may be added depending on the Institution

A person may be insured only under one class of eligible persons even though he or she may be eligible under more than one class.

Dependents, as defined by this Policy, of all Insureds are eligible for coverage under this Policy.

Students must actively attend classes for at least the first 31 consecutive days after the date for which coverage is purchased and meet the Institution's requirements for maintaining their status for coverage

A person may not be insured as a Dependent and an Insured at the same time.

An Insured's Dependent is eligible on the date:

- the Insured is eligible, if the Insured has Dependents on that date; or
- the date the person becomes a Dependent of the Insured, if later.
  In no event will a Dependent be eligible if the Insured is not enrolled for coverage under this Policy. Individuals who are eligible to receive Medicare benefits are not eligible to enroll in this Plan, unless they fall within a Federal exception.

No eligibility rules or variations in premium will be imposed based on a Student's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status factor. A Student will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or benefits of this Policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, is incentives and/or other programs do not constitute discrimination.

Schedule of Benefits

Covered Persons' benefits are highlighted below. However, to fully understand their benefits, it is very important that Covered Persons read this entire Policy. Although Covered Persons can go to the Hospital or Provider of their choice, benefits under the Policy will be greater when they use the services of a Network Provider.

The Institution may or may not have a Student Health Center Benefit. Students can talk to their Institution or visit baylor.myahpcare.com and select their Institution for specific details about their Student Health Center Benefits. Student Health Center benefits as described by the Institution.

The Institution may or may not have a Student Health Center Pharmacy Benefit. Students can talk to their Institution or visit baylor.myahpcare.com and select their Institution for specific details about their Student Health Center Pharmacy Benefits. Student Health Center Pharmacy benefits as described by the Institution.

Deductible:	**Network Provider**	**Out-of-Network Provider**
Per Covered Person per Benefit Period:	$500	$1,000
Per Family per Benefit Period	$1,500	$3,000
Out-of-Pocket Maximum:	**Network Provider**	**Out-of-Network Provider**
Per Covered Person per Benefit Period:	$6,350	$12,700
Per Family per Benefit Period	$12,700	$25,400
Covered Expenses	**Network Provider Covered Person Pays**	**Out-of-Network Provider* Covered Person Pays**
Inpatient Expenses		
Hospital Expenses	20% of Allowable Amount	40% of Allowable Amount
Surgical Expenses for a primary procedure - Remaining eligible procedures	20% of Allowable Amount	40% of Allowable Amount
Assistant Surgeon Services	20% of Allowable Amount	40% of Allowable Amount
Anesthetist Services	20% of Allowable Amount	40% of Allowable Amount
Doctor's Visits	20% of Allowable Amount	40% of Allowable Amount
Outpatient Expenses		
Surgical Expenses for a primary procedure - Remaining eligible procedures	20% of Allowable Amount	40% of Allowable Amount
Day Surgery Miscellaneous Expenses	20% of Allowable Amount	40% of Allowable Amount

Assistant Surgeon	20% of Allowable Amount	40% of Allowable Amount
Anesthetist	20% of Allowable Amount	40% of Allowable Amount
Emergency Room Accidents and Emergency Care (including Accidents and Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	20% of Allowable Amount subject to a $100 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	
Physician charges	20% of Allowable Amount	
Lab and x-ray charges	20% of Allowable Amount	
Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	20% of Allowable Amount subject to a $100 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)	40% of Allowable Amount subject to a $100 Copayment per visit (waived if admitted to the Hospital as an Inpatient immediately following emergency treatment)
Physician charges	20% of Allowable Amount	40% of Allowable Amount
Lab and x-ray charges	20% of Allowable Amount	40% of Allowable Amount
Urgent Care	No Deductible, subject to a $50 Copayment	40% of Allowable Amount, subject to a $50 Copayment
Outpatient Doctor's Visits	No Deductible -non-specialist subject to a $35 Copayment -specialist subject to a $45 Copayment	40% of Allowable Amount -non-specialist subject to a $35 Copayment -specialist subject to a $45
Habilitation Services Benefits will be limited to 35 visits per Benefit Period (Therapies associated with developmental delays will not be limited to annual or lifetime maximums)	20% of Allowable Amount	40% of Allowable Amount

Rehabilitation Services Benefits will be limited to 35 visits per Benefit Period (Therapies associated with developmental delays will not be limited to annual or lifetime maximums)	20% of Allowable Amount	40% of Allowable Amount
Diagnostic X-ray and Laboratory Services	20% of Allowable Amount	40% of Allowable Amount
Radiation and Chemotherapy	20% of Allowable Amount	40% of Allowable Amount
Allergy Injections and Allergy Testing	20% of Allowable Amount	40% of Allowable Amount
Home Infusion Therapy	20% of Allowable Amount	40% of Allowable Amount
Other Covered Expenses		
Durable Medical Equipment	20% of Allowable Amount	40% of Allowable Amount
Ground and Air Ambulance Services	20% of Allowable Amount	20% of Allowable Amount
Virtual Visits	Subject to a $35 Copayment	40% of Allowable Amount
Organ and Tissue Transplants	20% of Allowable Amount	40% of Allowable Amount
Maternity	20% of Allowable Amount	40% of Allowable Amount
Complications of Pregnancy	20% of Allowable Amount	40% of Allowable Amount
Routine Well-Baby Care	20% of Allowable Amount	40% of Allowable Amount
Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	20% of Allowable Amount
Tests and Procedures	20% of Allowable Amount	40% of Allowable Amount
Speech and Hearing Services Benefits for hearing aids will be limited to one hearing aid per ear each 36-month	20% of Allowable Amount	40% of Allowable Amount
Mental Health Care and Chemical Dependency	20% of Allowable Amount	40% of Allowable Amount
Extended Care Expenses		
Skilled Nursing Facility Benefits will be limited to 25 days per Benefit Period	20% of Allowable Amount	40% of Allowable Amount
Coordinated Home Health Care Benefits will be limited to 60 visits per Benefit Period	20% of Allowable Amount	40% of Allowable Amount

Hospice	20% of Allowable Amount	40% of Allowable Amount
Preventive Care Services	No Charge	40% of Allowable Amount
Additional Covered Expense State Mandated Benefits		
Mammography and Pap Smear Testing	No Charge	40% of Allowable Amount
Bone Density Testing	No Charge	40% of Allowable Amount
Prostate Cancer Screening	No Charge	40% of Allowable Amount
Colorectal Cancer Screening	No Charge	40% of Allowable Amount
Diabetes - includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services	20% of Allowable Amount	40% of Allowable Amount
Screening for early detection of cardiovascular disease limited to a maximum of 1 test every5 years for - men ages 46 to 75 years - women ages 56 to 75 years	20% of Allowable Amount	40% of Allowable Amount
Well Child Immunizations - birth through age 6	No Charge	No Charge
Screening Test for Hearing Loss - within 30 days from date of birth	20% of Allowable Amount	40% of Allowable Amount
Acquired Brain Injury - includes multiple therapies and rehabilitation treatments	20% of Allowable Amount	40% of Allowable Amount
Temporomandibular and Craniomandibular Joint Disorders - includes diagnosis and surgical treatment	20% of Allowable Amount	40% of Allowable Amount
Autism Spectrum Disorders for covered dependent.	20% of Allowable Amount	40% of Allowable Amount
Clinical Trial Programs - routine patient costs for Phase I, II, III or IV trials	20% of Allowable Amount	40% of Allowable Amount
Amino Acid-Based Formulas – if Doctor orders Medically Necessary	20% of Allowable Amount	40% of Allowable Amount
Mastectomy and Lymph Node Dissection – minimum inpatient stay	20% of Allowable Amount	40% of Allowable Amount
Inheritable Metabolic Disorders	20% of Allowable Amount	40% of Allowable Amount

Prosthetic and Orthotic Devices – limited to most appropriate model that meets medical needs	20% of Allowable Amount	40% of Allowable Amount
Cochlear Implants – limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	20% of Allowable Amount	40% of Allowable Amount
Craniofacial Abnormalities	20% of Allowable Amount	40% of Allowable Amount
Telehealth and Telemedicine Services	20% of Allowable Amount	40% of Allowable Amount
Orally Administered Anticancer Medication – when MedicallyNecessary	20% of Allowable Amount	40% of Allowable Amount
Preauthorization Requirements		
Inpatient Admissions – Penalty for failure to preauthorize inpatient admissions shown in the Preauthorization Requirements section of the Policy	None	$250

The Copayment and Coinsurance amounts mentioned above are subject to change or increase as permitted by applicable law.

***Covered Persons will be responsible for the difference between the Allowable Amount and the billed charges, when receiving Covered Services from an Out-of-Network Provider. For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Texas Customer Service at 1-855-267-0214.**

Schedule of Benefits for Outpatient Prescription Drugs

Student Health Center Pharmacy Benefit

Copayments for Student Health Center Pharmacy Benefit*:	Student Health Center Pharmacy Covered Person Pays
Generic Drugs and generic diabetic supplies and insulin and insulin syringes	$15 per prescription
Preferred Brand Name Drugs and preferred brand name diabetic supplies and insulin and insulin syringes	$30 per prescription
Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	$50 per prescription

*One prescription means up to a 30-consecutive day supply of a drug (except for certain drugs).

Outpatient Prescription Drug Program

The Institution may or may not have a Student Health Center Pharmacy Benefit. Students can talk to their Institution or visit baylor.myahpcare.com and select their Institution for specific details about their Student Health Center Pharmacy Benefits. Student Health Center Pharmacy benefits as described by the Institution

Copayments for Outpatient Prescription Drugs*:	Network Provider Pharmacy Covered Person Pays**	Out-of-Network Pharmacy Covered Person Pays**
Generic Drugs and generic diabetic supplies and insulin and insulin syringes	$20 per prescription	$20 per prescription
Preferred Brand Name Drugs and preferred brand name diabetic supplies and insulin and insulin syringes	$40 per prescription	$40 per prescription
Non-Preferred Brand Name Drugs and non-preferred brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	$60 per prescription	$60 per prescription

* One prescription means up to a 30-consecutive day supply of a drug (except for certain drugs). Covered Persons can purchase a 90-day supply for 3 times the retail amount.

** Out-of-Network Pharmacies: When a Covered Person obtains Prescription Drugs, including diabetic supplies from an Out-of-Network Pharmacy (other than a Network Pharmacy), benefits will be provided at 60% of the amount a Covered Person would have received had he/she obtained drugs from a Network Pharmacy minus the Copayment amount or Coinsurance amount.

Covered Persons will be responsible for the difference between the Allowable Amount and the billed charges, when receiving Prescription Drugs from an Out-of-Network Pharmacy.

Important Information

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

Unless otherwise specified, any Deductibles, Out-of-Pocket Maximums, Copayments, Coinsurance percentages and Benefit Maximums apply on a per Covered Person, per Benefit Period basis.

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

DEDUCTIBLE

After the Deductible and any Copayments have been satisfied, benefits will be paid at the applicable benefit rate up to any maximum that may apply.

If a Student has Family Coverage, each member of his/her family must satisfy the Deductible. If a Student's family has satisfied the family deductible amount of $1,500 for Covered Expenses rendered by Network Provider(s) and a separate $3,000 family deductible for Covered Expenses rendered by Out-of-Network Provider(s), it will not be necessary for anyone else in a Student's family to meet the Deductible in that Benefit Period. That is, for the remainder of that Benefit Period only, no other family members(s) will be required to meet the Deductible before receiving benefits.

OUT-OF-POCKET MAXIMUM

Once the Out-of-Pocket Maximum has been satisfied, Covered Expenses will be payable at 100% for the remainder of the Benefit Period up to any maximum that may apply.

The Network Out-of-Pocket Maximum may be reached by:

- the Network Deductible
- charges for the Outpatient Prescription Drugs
- the Hospital emergency room Copayment
- the Copayment for Doctor office visits
- the Copayment for specialist's office visits
- the payments for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room or any expenses incurred for Covered Services rendered by an Out-of-Network Provider other than Emergency Care, and Inpatient treatment during the period of time when a Covered Person's condition is serious)

The following expenses cannot be applied to the Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Amount when a Covered Person's Network Out-of-Pocket Maximum is reached:

- charges that exceed the Allowable Amount
- the Coinsurance resulting from Covered Services rendered by an Out-of-Network Provider
- penalty amounts for failing to follow preauthorization requirements
- services, supplies, or charges limited or excluded in this Policy
- expenses not covered because a benefit maximum has been reached
- any Covered Expenses paid by the Primary Plan when BCBSTX is the secondary plan for purposes of coordination of benefits

The Out-of-Network Out-of-Pocket Maximum may be reached by:

- the Out-of-Network Deductible
- the Hospital emergency room Copayment
- the payments for Covered Services rendered by an Out-of-Network Provider for which a Covered Person is responsible after benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room)

The following expenses cannot be applied to the Out-of-Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Amount when a Covered Person's Out-of-Network Out-of-Pocket Maximum is reached:

- charges that exceed the Allowable Amount
- the Coinsurance resulting from Covered Services a Covered Person may receive from a Network Provider
- penalty amounts for failing to follow preauthorization requirements
- services, supplies, or charges limited or excluded in this Policy
- expenses not covered because a benefit maximum has been reached
- any Covered Expenses paid by the Primary Plan when BCBSTX is the secondary plan for purposes of coordination of benefits

If a Student has Family Coverage, each member of his/her family must satisfy the Out-of-Pocket Maximum. If a Student's family has satisfied the family out-of-pocket maximum of $12,700 for Covered Expenses rendered by Network Provider(s) and a separate $25,400 family out-of-pocket maximum for Covered Expenses rendered by Out-of-Network Provider(s), it will not be necessary for anyone else in a Student's family to meet the Out-of-Pocket Maximum in that Benefit Period. That is, for the remainder of that Benefit Period only, no other family member(s) will be required to meet the Out-of-Pocket Maximum before Covered Expenses (except for those expenses specifically excluded above) will be payable at 100%.

Should the federal government adjust the Deductible(s) and/or Out-of-Pocket Maximum(s) applicable to this type of coverage, the Deductible and/or the Out-of-Pocket Maximum(s) in this Policy will be adjusted accordingly.

Preauthorization Requirements

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

The following types of services require Preauthorization:

- All inpatient admissions,
- Extended Care Expense,
- Home Infusion Therapy,
- Diagnostic Studies for Obstructive Sleep Apnea,
- Outpatient Radiation Therapy,
- All inpatient treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care,
- If you transfer to another facility or to or from a specialty unit within the facility.
- The following outpatient treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care:
  - Psychological testing;
  - Neuropsychological testing;
  - Electroconvulsive therapy;
  - Repetitive transcranial magnetic stimulation;
  - Applied behavior analysis;
  - Intensive Outpatient Program

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least three hours per day, two or more days per week, to treat mental illness, drug addiction, substance abuse or alcoholism, or specializes in the treatment of co-occuring mental illness with drug addiction, substance abuse or alcoholism. These programs offer integrated and aligned assessment, treatment and discharge planning services for treatment of severe of complex co-occuring conditions which make it unlikely that the Covered Person will benefit from programs that focus solely on mental illness conditions.

Your Network Provider is required to obtain Preauthorization for inpatient Hospital admissions. You are responsible for satisfying all other Preauthorization requirements. This means that you must ensure that you, your family member, your Physician, Behavioral Health Practitioner or Provider of services must comply with the guidelines below. Failure to Preauthorize services will require additional steps and/or benefit reductions as described in the section entitled *Failure to Preauthorize.*

Preauthorization for Inpatient Admissions
In the case of an elective inpatient admission, the call for Preauthorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, Preauthorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

Your Network Provider is required to obtain Preauthorization requirements for any inpatient admissions. If Physician or Provider of services is not a Network Provider then you, your Physician, Provider of services, or a family member should obtain Preauthorization by the Plan by calling one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 6:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned not later than 24 hours after the call is received. We will follow up with your Provider's office. After working hours or on weekends, please call the Medical Preauthorization Helpline toll-free number listed

on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations**.**

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not reasonably available from Network Providers as defined by applicable law, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When an inpatient admission is Preauthorized, a length-of-stay is assigned. If you require a longer stay than was first Preauthorized, your Provider may seek an extension for the additional days. Benefits will not be available for room and board charges for medically unnecessary days.

Preauthorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested
Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery
  - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
  - 48 hours following a mastectomy
  - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Preauthorization from BCBSTX for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you or your Provider must seek an extension for the additional days by obtaining Preauthorization from BCBSTX.

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

- Prior to initiating Extended Care Expense or Home Infusion Therapy;
- When an extension of the initially Preauthorized service is required; and
- When the treatment plan is altered.

BCBSTX will review the information submitted prior to the start of Extended Care Expense or Home Infusion Therapy and will send a letter to you and the agency or facility confirming Preauthorization or denying benefits. If Extended Care Expense or Home Infusion Therapy is to take place in less than one week, the agency or facility should call the BCBSTX **Medical Preauthorization Helpline** telephone number indicated in this Benefit Booklet or shown on your Identification Card.

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

Preauthorization for Diagnostic Studies for Obstructive Sleep Apnea
In order to receive maximum benefits, Diagnostic Studies for Obstructive Sleep Apnea must be Preauthorized by the Plan. It is recommended that services obtained from an In-Network or Out-of-Network Provider be preauthorized 2 business days prior to receipt of the service. To satisfy Preauthorization requirements, on business days between 6:00

a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card.

Preauthorization for Outpatient Radiation Therapy
In order to receive maximum benefits, outpatient radiation therapy must be Preauthorized by the Plan. It is recommended that services obtained from an In-Network or Out-of-Network Provider be preauthorized 2 business days prior to receipt of the service. To satisfy Preauthorization requirements, on business days between 6:00 a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll-free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll-free number listed on the back of your Identification Card.

Preauthorization for Chemical Dependency, and Serious Mental Illness and Mental Health Care
In order to receive maximum benefits, all inpatient treatment for Chemical Dependency, Serious Mental Illness, and Mental Health Care must be Preauthorized by the Plan. Preauthorization is also required for certain outpatient services. Outpatient services requiring Preauthorization include psychological testing, neuropsychological testing, repetitive transcranial magnetic stimulation, Intensive Outpatient Programs, applied behavior analysis and electroconvulsive therapy. Preauthorization is not required for therapy visits to a Physician, Behavioral Health Practitioner and/or Professional Other Provider.

To satisfy Preauthorization requirements, you, a family member, or your Behavioral Health Practitioner must call the **Mental Health/Chemical Dependency Preauthorization Helpline** toll-free number indicated in this Benefit Booklet or shown on your Identification Card. The **Mental Health/Chemical Dependency Preauthorization Helpline** is available 24 hours a day, 7 days a week. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations**.**

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid. In-Network and Out-of-Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

However, if care is not reasonably available from Network Providers as defined by applicable law, and BCBSTX authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of Network Benefits will be paid.

When a treatment or service is Preauthorized, a length of stay or length of service is assigned. If you require a longer stay or length of service than was first Preauthorized, your Behavioral Health Practitioner may seek an extension for the additional days or visits. Benefits will not be available for medically unnecessary treatments or services.

Failure to Preauthorize
If Preauthorization for inpatient admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and the above specified outpatient treatment of Chemical Dependency, Serious Mental Illness, and Mental Health Care is not obtained:

- BCBSTX will review the Medical Necessity of your treatment or service prior to the final benefit determination.
- If BCBSTX determines the treatment or service is not Medically Necessary or is Experimental/Investigational, benefits will be reduced or denied.
- You may be responsible for a penalty in connection with the following Covered Services, if indicated on your Schedule of Coverage:
  - Inpatient admission
  - Inpatient treatment of Chemical Dependency, Serious Mental Illness, or Mental Health Care

Network Providers are responsible for satisfying the Preauthorization requirements for any inpatient admissions. For Out-of-Network Providers, any penalty charge will be deducted from any benefit payment which may be due for Covered Services.

RADIOLOGY QUALITY INITIATIVE (RQI) PROGRAM

An RQI number is required by BCBSTX prior to performing any of the high-tech, elective, non-emergency diagnostic imaging services listed below for Covered Persons:

- CT and CTA scans
- MRI and MRA scans
- Nuclear Cardiology studies
- PET scans

The RQI program applies to all of the above imaging services when performed in a Physician's office, the outpatient department of a Hospital or a freestanding imaging center. Ordering Physicians can obtain, and imaging service Providers can confirm, a Covered Person's RQI number via American Imaging Management's (AIM's) website at www.aimspecialtyhealth.com. Additional information about AIM and the RQI process is available in the Clinical Resources/Radiology Quality Initiative (RQI) section of Our website at www.bcbstx.com/provider.

Note: If an RQI number cannot be issued, a Covered Person will be directed back to BCBSTX to complete the predetermination process. The RQI program is not a substitute for the pre-certification process.

Definitions

Throughout this Policy, many words are used which have a specific meaning when applied to a Covered Person's health care coverage. These terms will always begin with a capital letter. When a Covered Person comes across these terms while reading this Policy, he/she can refer to these definitions because they will help them understand some of the limitations or special conditions that may apply to his/her benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these definitions. All definitions have been arranged in ALPHABETICAL ORDER. In this Policy We refer to Our Company as "Blue Cross and Blue Shield" and We refer to the institution of higher education in which a Student is enrolled and active as the "Institution."

"Accident" means a sudden, unexpected and unintended identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

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

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

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

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

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

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

The non-contracting Allowable Amount does not equate to the Provider's billed charges and Covered Persons 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, Covered Persons may call customer service at 1-855-267-0214.

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 Prescription Drugs as applied to Network Provider and Out-of-Network Provider Pharmacies - The Allowable Amount for pharmacies that are Network Providers will be based on the provisions of the contract between BCBSTX and the Pharmacy in effect on the date of service. The Allowable Amount for pharmacies that are not Network Providers will be based on the Average Wholesale Price.

For Out-of-Network Emergency Care and care provided by an Out-of-Network Provider when a Network Provider is not reasonably available as defined by applicable law – The Allowable Amount will be the usual or customary charge as defined by Texas law or as prescribed under applicable law or regulations. Such claims will be paid at the Network Benefit coinsurance level and in addition to any amounts that would have been credited had the provider been a Network Provider, we will credit You any out-of-pocket amounts you actually paid to the Out-of-Network Provider for charges for covered services that were above and beyond the allowed amount toward Your deductible and annual out-of-pocket maximum applicable to in-network services.

"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.

"Behavioral Health Practitioner" means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency.

"Benefit Period" means the period of time starting with the Effective Date of this Policy through the Termination Date as shown on the Face page of the Policy. The Benefit Period is as agreed to by the Policyholder and the Insurer.

"Brand Name Drug" means a drug or product manufactured by a single manufacturer as defined by a nationally recognized provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic to Preferred or Non-Preferred Brand Name due to a change in the market resulting in the Generic Drug

being a single source, or the drug product database information changing, which would also result in a corresponding change to a Covered Person's payment obligations from Generic to Preferred or Non-Preferred Brand Name.

"Certain Diagnostic Procedures" means:

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)

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

"Chemical Dependency Treatment Center" means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Behavioral Health Practitioner and which facility is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or
2. Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
3. Licensed as a chemical dependency treatment program by an agency of the state of Texas having legal authority to so license, certify or approve; or
4. Licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

"Claim" means notification in a form acceptable to Us that a service has been rendered or furnished to the Covered Person. This notification must include full details of the service received, including the Covered Person's name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished (including appropriate codes), the date of the service, the diagnosis (including appropriate codes), the Claim Charge, and any other information which We may request in connection with services rendered to the Covered Person.

"Claim Charge" means the amount which appears on a Claim as the Provider's charge for services rendered to the Covered Person, without adjustment or reduction and regardless of any separate financial arrangements between Us and a particular Provider.

"Claim Payment" means the benefit payment calculated by Blue Cross and Blue Shield, after submission of a Claim, in accordance with the benefits described in this Policy. All Claim Payments will be calculated on the basis of the Allowable Amount for Covered Services rendered to a Covered Person, regardless of any separate financial arrangement between Blue Cross and Blue Shield and a particular Provider. (See provisions of this Policy regarding "Blue Cross and Blue Shield's Separate Financial Arrangements with Providers.")

"Coinsurance" means a percentage of an eligible expense that the Covered Person is required to pay towards a Covered Expense.

"Company" means Blue Cross and Blue Shield of Texas, A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association (also referred to herein as "BCBSTX").

"Complications of Pregnancy" means:

- Conditions, requiring Hospital Confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as 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, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy, and
- 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.

"Copayment" means a fixed dollar amount that the Covered Person must pay before benefits are payable under the Policy. "Covered Accident" means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

"Covered Accident" means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

"Covered Expenses" means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date the Accident or Sickness occurs until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

"Covered Oral Surgery" means maxillofacial surgical procedures limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the Plan; and
5. Removal of complete bony impacted teeth.

"Covered Person" means any eligible Student or an eligible Dependent who applies for coverage, and for whom the required premium is paid to Us.

"Covered Service" means a service or supply specified in this Policy for which benefits will be provided.

"Crisis Stabilization Unit or Facility" means an institution which is appropriately licensed and accredited as a Crisis Stabilization Unit or Facility for the provision of Mental Health Care and Serious Mental Illness services to Covered Persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

"Custodial Care" means any service primarily for personal comfort for convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care Services also means those services, which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

"Deductible" means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a Policy Term basis before benefits are payable under the Policy.

"Dependent" means:

- an Insured's lawful spouse; or
- an Insured's child(ren)
- "Child(ren)" used hereafter in this Policy, means a natural child(ren), a stepchild(ren), foster child(ren), adopted child(ren), (including a child(ren) for whom a Student is a party in a suit in which the adoption of the child(ren) is sought), a child(ren) of a Student's child(ren), grandchild(ren), child(ren) for whom a Student is the legal guardian under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors.

Coverage will continue for a child who is 26 or more years old, chiefly supported by the Insured and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Us within 31 days after the date the child ceases to qualify as a child for the reasons listed above. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

"Doctor" means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate. It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

"Drug List" means a list of drugs that may be covered under the Outpatient Prescription Drug Program section of this Policy. This list is available by accessing the website at www.bcbstx.com. Covered Persons may also contact Customer Service at 1-855-267-0214 for more information. BCBSTX will routinely review the Drug List and periodically adjust it to modify the Preferred or Non-Preferred Brand Name Drug status of existing or new drugs. Changes to this list will occur as frequently as quarterly. The Drug List and any modifications will be made available to Covered Persons.

"Emergency Care" means health care services provided in a Hospital emergency facility (emergency room), freestanding emergency medical care 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 care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment of bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Emergency services" means, with respect to an emergency medical condition, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and, within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize the patient.

"Experimental or 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, device, 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:

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

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

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

"Extended Care Expenses" means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Coordinated Home Health Agency, or a Hospice as described in the Benefit Description section of this Policy.

"Family Coverage" means coverage for a Student and his/her eligible spouse and/or Dependents under this Policy.

"Generic Drug" means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Prescription Drugs and corresponding payment level, Blue Cross and Blue Shield utilizes the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of Generic Drugs is available by accessing the website at *www.bcbstx.com*. A Covered Person may also contact a Customer Service at 1-855-267-0214 for more information.

"Habilitation Services" means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/ or outpatient settings.

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

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

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

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

"Hospital" means a short-term acute care facility which:

- Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
- 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 or Behavioral Health Practitioners for compensation from its patients;
- Has organized departments of medicine and 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;
- Provides 24-hour nursing services by or under the supervision of a Registered Nurse;
- Has in effect a Hospital Utilization Review Plan; and

Hospital also means a licensed alcohol and drug abuse rehabilitation facility or a mental hospital. Alcohol and drug abuse rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

"Hospital Confined" means a stay as a registered bed-patient in a Hospital. If a Covered Person is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed-patient during for the duration in the Hospital, the admission shall be considered a Hospital Confinement.

"Immediate Family" means a Covered Person's parent, spouse, child, brother or sister.

"Injury" means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"Inpatient" means that a Covered Person is a registered bed patient and is treated as such in a health care facility.

"Institution" means an institution of higher education as defined in the Higher Education Act of 1965.

"Insured" means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

"Interscholastic Activities" means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

"Life-Threatening Disease or Condition" means, for the purposes of a clinical trial, any disease or condition from which the likelihood of death is probably unless the course of the disease or condition is interrupted.

"Medical Care" means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an illness or injury.

"Medically Necessary" means those services or supplies covered under the Plan which are:

- 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
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an Outpatient.

The medical staff of BCBSTX shall determine whether a service or supply is Medically Necessary under the Plan 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, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment; such treatment may not be Medically Necessary within this definition.

"Mental Health Care" means any one or more of the following:

1. The diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, or any other diagnostic coding system as used by the Carrier, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;

2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Covered Expense is:
   a. Individual, group, family, or conjoint psychotherapy,
   b. Counseling,
   c. Psychoanalysis,
   d. Psychological testing and assessment,
   e. The administration or monitoring of psychotropic drugs, or
   f. Hospital visits or consultations in a facility listed in subsection 5, below;
3. Electroconvulsive treatment;
4. Psychotropic drugs;
5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, facility other Provider, or other licensed facility or unit providing such care.

"Network Pharmacy" means an independent retail Pharmacy, or chain of retail Pharmacies, which has entered into a written agreement with BCBSTX to provide pharmaceutical services to Covered Persons under the Policy.

"Network Provider" means a Hospital, Doctor or other Provider who has entered into an agreement with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider.

"Non-Preferred Brand Name Drug" means a Brand Name Drug which appears on the applicable Drug List and is subject to the Non-Preferred Brand Name Drug Copayment. This Drug List is available by accessing the website at www.bcbstx.com.

"Out-of-Network Provider" means a Hospital, Doctor or other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider.

"Out-of-Pocket Maximum" means the maximum liability that may be incurred by a Covered Person in a Benefit Period before benefits are payable at 100% of the Allowable Amount.

"Outpatient" means that a Covered Person is receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether a Covered Person is subsequently registered as an Inpatient in a health care facility.

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

"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.

"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, and includes, but is not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotics or prosthetic training.

"Policy" means this Policy issued by Blue Cross and Blue Shield to the Institution, any addenda, the Institution's Application for Student Blanket Health Insurance, the Covered Person's application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

"Preauthorization" means the process that determines in advance the Medical Necessity or Experimental / Investigational nature of certain care and services under this Policy.

"Preferred Brand Name Drug" means a brand name prescription drug product that is identified as a Preferred Brand Name Drug on the applicable Drug List and is subject to the Preferred Brand Name Drug Copayment. This list is available by accessing the website at www.bcbstx.com.

"Prescription Drugs" mean 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) prescription drugs that have been approved by the FDA for one protocol will be covered when found to be effective and prescribed for another; 4) any other drugs that under the applicable state or federal law may be dispensed only upon written prescription of a Doctor.

Prescription drugs will also include FDA approved female contraceptive drugs and devices and Outpatient contraceptive services.

"Prescription Order" means a written or verbal order from a Health Care Practitioner to a pharmacist for a drug to be dispensed. Orders written by a Health Care Practitioner located outside the United States to be dispensed in the United States are not covered under this Policy.

"Provider" means a Hospital, Physician, Behavioral Health Practitioner, Other Provider, or any other person, company, or institution furnishing to a Covered Person an item of service or supply listed as Covered Expenses.

"Psychiatric Day Treatment Facility" means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care and Serious Mental Illness services to Covered Persons for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician or Behavioral Health Practitioner to be in lieu of hospitalization.

"Qualifying Intercollegiate Sport" means a sport: a.) which is not an Interscholastic Activity (as defined in this Policy); and (b.) which is administered by such Institution's department of intercollegiate athletics; and (c.) for which benefits for Covered Accidents are provided for and payable under this Policy while Insureds are playing, participating, and/or traveling to or from an intercollegiate sport, contest or competition, including practice or conditioning for such activity.

"Rehabilitation Services" means services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

"Rescission" means a cancellation or discontinuance of coverage that has retroactive effect except to the extent

attributable to a failure to timely pay premiums.

"Serious Mental Illness" means the following psychiatric illnesses defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or recurrent);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); or
7. Schizophrenia.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Specialty Drugs" means Prescription Drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected, but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, a Covered Person should contact his/her Pharmacy, refer to the Drug List by accessing the website at www.bcbstx.com or contact Customer Service at 1-855-267-0214.

"Specialty Pharmacy Provider" means a Participating Prescription Drug Provider that has a written agreement with Blue Cross and Blue Shield of Texas or the entity chosen by Blue Cross and Blue Shield of Texas to administer its prescription drug program to provide Specialty Drugs to Covered Persons.

"Student(s)" means an individual student or continued person who meets the eligibility requirements for this health coverage, as described in the eligibility requirements of this Policy.

"Student Administrative Health Fee" means a fee charged by the Institution on a periodic basis to Students of the Institution to offset the cost of providing health care through health clinics regardless of whether the Students utilize the health clinics or enroll in student health insurance. Student Administrative Health Fees are not considered Deductibles, Coinsurance, Copayments or other "cost sharing" for purposes of Preventive Care Services benefit, and do not count toward maximums.

"Surgery" means the performance of any medically recognized, non-Experimental/Investigational surgical procedure including specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by Blue Cross and Blue Shield.

"Virtual Network Provider" means a licensed Participating Provider that has entered into a contractual agreement with BCBSTX to provide diagnosis and treatment of injuries and illnesses through either (i) interactive audio communication (via telephone or other similar technology), or (ii) interactive audio/video examination and communication (via online portal, mobile application or similar technology).

"Virtual Visits" means services provided for the treatment of non-emergency medical and behavioral health conditions as described in Benefits for Virtual Visits provision

"We, Our, Us" means Blue Cross and Blue Shield of Texas or its authorized agent.

Effective Date of Insurance

Insurance for an Eligible Person who enrolls during the program's enrollment period, as established by the school, is effective on the latest of the following dates:

- the Policy Effective Date;
- the date We receive the completed enrollment form;
- the date after the required premium is paid; or
- the date the Student enters the Eligible Class.

Coverage for a Student's eligible Dependent who enrolls:

- during the enrollment period established by the Policyholder; or
- within 31 days after the Student acquires a new Dependent; or
- within 31 days after a Dependent terminates coverage under another Health Care Plan,

is effective on the latest of the following dates:

- the first day of the Coverage Period;
- the date the Student enters the Eligible Class;
- the date We receive the completed enrollment form; and
- the date after the required premium is paid.

After the time periods described above, the Student or Dependent must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another Health Care Plan.

We will pay benefits for a newborn child of a Covered Person until that child is 31 days old. Coverage may be continued beyond the 31 days if the Covered Person notifies Us of the child's birth and pays the required premium, if any.

Adopted children, as defined by the Policy, will be covered on the same basis as a newborn child from the date the Insured becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and the Insured's legal obligation terminates.

Coverage for newborn and adopted children will consist of coverage for covered Injury or covered Sickness including the necessary care and treatment of medically diagnosed congenital defects, prematurity, well born care, birth abnormalities, and routine nursery care related with a covered Sickness.

OPEN ENROLLMENT PERIODS

Academic HealthPlans, along with the Institution will designate open enrollment periods during which Students may apply for or change coverage for himself/herself and/or his/her eligible spouse and/or Dependents.

This section "Open Enrollment Periods" is subject to change by Blue Cross and Blue Shield, and/or applicable law, as appropriate.

QUALIFYING EVENT

Eligible Students and eligible Dependents who have a change in status and lose coverage under another Health Care Plan are eligible to enroll for coverage under the Policy provided, within 31 days of the qualifying event, such Students must send to Academic HealthPlans with a completed qualifying events form and the letter of

ineligibility. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce or annulment, gain of a Dependent whether by birth, adoption, or suit for adoption or court-ordered Dependent coverage, or loss of dependent status because of age. The premium will be prorated based on what it would have been at the beginning of the semester or quarter, whichever applies. However, the Effective Date will be the later of the date the Student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends.

Discontinuance of Insurance

TERMINATION DATE OF INSURANCE

An Insured's coverage will end on the earliest of the date:

- the Policy terminates;
- the Insured is no longer eligible; or
- the period ends for which premium is paid.

Dependent's coverage will end on the earliest of the date:

- he or she is no longer a Dependent;
- the Insured's coverage ends; or
- the period ends for which premium is paid; or
- the Policy terminates.

REFUND OF PREMIUM

A pro-rata refund of premium will be made only in the event:

- of a Covered Person's death; or
- a Covered Person ceases to maintain eligibility; or
- the Covered Person enters full-time active duty in any Armed Forces; and
- We receive proof of such active duty service.

EXTENSION OF BENEFITS

If a Covered Person is confined in a Hospital for a medical condition on the date his/her coverage under this Policy is terminated, expenses Incurred during the continuation of that Hospital stay will be considered a Covered Expense, but only while such expenses are incurred during the 90-day period following the termination of insurance. We will not continue to pay these Covered Expenses if:

- the Covered Person's medical condition no longer continues;
- the Covered Person reaches any maximum that may apply; or
- the Covered Person obtains other coverage;
- the Covered Expenses are incurred more than 3 months following termination of insurance.

CONTINUATION OF COVERAGE

A Covered Person who has been insured under the Policy may continue to be insured under the Policy when coverage terminates subject to the following:

- Continuation of Coverage is available to Students and their covered Dependents, when the student leaves school, dies, or when the covered Dependent no longer qualifies as an eligible Dependent.
- The Covered Person requesting coverage must have been insured under the Policy for at least 5 months.
- Requests for Continuation of Coverage, with the applicable premium, must be submitted within 30 days of:
  - the date the existing coverage would otherwise terminate; or
  - the date the Covered Person is notified of the right to continue the coverage.
- Coverage and Benefits will be the same as those, which are applicable prior to continuation.
- Premium rates for Continuation of Coverage may be higher than Student rates.
- The maximum period for which coverage may be continued is 6 months.

Accident and Sickness Medical Expense Benefits

We will pay the Covered Expenses as shown in the Benefit Highlights if a Covered Person requires treatment by a Doctor. We will consider the Allowable Amount incurred for Medically Necessary Covered Expenses. Benefit payments are subject to the Deductibles, Copayments and Coinsurance factors shown in the Schedule of Benefits and the Benefit Highlights and benefit maximums, if any, shown in the Benefit Description as well as any other terms, conditions, limitations, or exclusions described in this Policy.

Covered Expenses include:

Hospital Expenses:

- Daily room and board at semi-private room rate when Hospital Confined;
- General nursing care provided and charged for by the Hospital;
- Intensive care. We will make this payment in lieu of the semi-private room expenses;
- Coordinated home care benefits following Hospital Confinement;
- Hospital Miscellaneous Expenses: expenses incurred while Hospital Confined or as a precondition for being Hospital Confined, for services and supplies such as the cost of operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, physical therapy, therapeutic services and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.

- Surgical Expense: Surgeon's fees for Inpatient Surgery paid as shown in the Benefit Highlights. If an Injury or Sickness requires multiple surgical procedures, We will cover according to the Allowable Amount shown in the Benefit Highlights.
- Preadmission Testing: when Medically Necessary, in connection with Inpatient Surgery.
- Assistant Surgeon Services: When Medically Necessary, in connection with Inpatient Surgery.
- Anesthetist Services: in connection with Inpatient Surgery.
- Doctor's Visits: when Hospital Confined. Benefits do not apply when related to Surgery and will be paid as a Covered Inpatient Expense as shown in the Benefit Highlights.
- Staff nursing care while confined to a Hospital by a licensed registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN).

Outpatient Expenses

- Day Surgery/Outpatient Surgical Expense: Surgeon's fees for Outpatient Surgery paid as shown in the Benefit Highlights. If an Injury or Sickness requires multiple surgical procedures, We will cover according to the Allowable Amount shown in the Benefit Highlights.
- Day Surgery Miscellaneous Expenses: Services related to scheduled Surgery performed in a Hospital or ambulatory surgical center, including operating room expenses, laboratory tests and diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines; therapeutic services and supplies. Benefits will not be paid for: Surgery performed in a Hospital emergency room, Doctor's office, or clinic.
- Preadmission Testing: when Medically Necessary, in connection with Outpatient Surgery.
- Assistant Surgeon Services: when Medically Necessary, in connection with Outpatient Surgery.
- Anesthetist Services: in connection with Outpatient Surgery.
- Doctor's Visits: Benefits will be paid as shown in the Benefit Highlights. Doctor visits related to

Surgery will not be subject to a Copayment, and benefits will be paid as a Covered Outpatient Expense as shown in the Benefit Highlights.

- Virtual Visits: Benefits will be paid as shown in the Benefit Highlights., and benefits will be paid as a Covered Outpatient Expense as shown in the Benefit Highlights.
- Home Infusion Therapy will be paid as shown in the Benefit Highlights.
- Habilitation Services; includes, but is not limited to physical, occupational, speech therapy evaluations and services, dietary or nutritional evaluations, and manipulative therapy. Benefits for Habilitation Services will be limited to 35 visits per Benefit Period. Therapies associated with developmental delays will not be limited to annual or lifetime maximums.
- Rehabilitation Services; includes, but is not limited to physical, occupational, speech therapy evaluations and services, dietary or nutritional evaluations, and manipulative therapy. Benefits for Habilitation Services will be limited to 35 visits per Benefit Period. Therapies associated with developmental delays will not be limited to annual or lifetime maximums.
- Diagnostic X-ray and Laboratory Services: when Medically Necessary and performed by a Doctor will include diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits, X-ray and lab procedures.
- Medical Emergency Expenses: only in connection with Emergency Care as defined. Benefits will be paid as shown in the Benefit Highlights for the use of the emergency room and supplies.
- Urgent Care
- Radiation & Chemotherapy
- Allergy Injections and Allergy Testing

Other Expenses

- Durable Medical Equipment, Prosthetics, Braces and Appliances, and medical services: for Medically Necessary services: 1) when prescribed by a Doctor; and 2) a written prescription accompanies the claim when submitted. Replacement or repairs to braces and appliances are not covered. Durable, medical equipment is equipment that:
    - is primarily and customarily used to serve a medical purpose;
    - can withstand repeated use; and
    - generally is not useful to person in the absence of Injury.

No benefits will be paid for rental charges in excess of the purchase price.

- Ambulance Service. Payment will be made to the Provider as shown in the Benefit Highlights.
- Consultant Doctor Fees: when requested and approved by the attending Doctor.
- The Insurer will pay the actual expenses incurred, including Medically Necessary maternity testing, as a result of pregnancy, childbirth, miscarriage, or any Complications of Pregnancy resulting from any of these Pregnancy benefits will also cover a period of hospitalization for maternity and newborn infant care for:
    - a minimum of 48 hours of Inpatient care following a vaginal delivery; or
    - a minimum of 96 hours of Inpatient care following delivery by cesarean section.

Covered Persons' Providers will not be required to obtain authorization from Blue Cross and Blue Shield for prescribing a length of stay less than 48 hours (or 96 hours).

If the Doctor, in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a Provider's office, as determined by the Doctor in consultation with the mother. The at-home post-

delivery care shall be provided by a registered professional nurse, Doctor, nurse practitioner, nurse midwife, or Physician's assistant experienced in maternal and child health, and shall include:

- Parental education;
- Assistance and training in breast or bottle feeding; and
- Performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

- Routine Well-Baby Care: 1) while the baby is Hospital Confined; and 2) for routine nursery care provided within the first 31 days after birth, including treatment of diagnosed congenital and birth abnormalities.
- Dental Treatment (Injury Only): when performed by a Doctor and made necessary by Injury to sound, natural teeth. If there is more than one way to treat a dental problem, We will pay based on the least expensive procedure if that procedure meets commonly accepted dental standards of the American Dental Association.
- Covered Oral Surgery.
- Tests and Procedures: diagnostic services and medical procedures performed by a Doctor, other than Doctor's Visits, Physical Therapy and X-rays and Lab procedures.
- Treatment for loss or impairment of speech or hearing: Benefits will be paid for incurred expenses the same as for treatment of any other sickness subject to the Hearing Aid maximum specified below.
- Hearing Aids: Benefits for Covered Expenses incurred for services to restore the loss of or correct an impaired speech or hearing function with hearing aids will be the same as any other sickness. Limited to one hearing aid per ear each 36-month period.
- Screening for Early Detection Tests for Cardiovascular Disease: Benefits will be paid for noninvasive screening tests for atherosclerosis and abnormal artery structure and function when performed by a laboratory that is certified by a recognized national organization as shown in the Benefit Highlights:
  - Computed tomography (CT) scanning measuring coronary artery calcifications; or
  - Ultrasonography measuring carotid intima-media thickness and plaque.
- Skilled Nursing Facility. Subject to the Preauthorization guidelines set forth in this Policy and limited to a maximum of 25 days per Benefit Period.
- Coordinated Home Health Care. Subject to the Preauthorization guidelines set forth in this Policy and limited to a maximum of 60 visits per Benefit Period.
- Hospice. Subject to the Preauthorization guidelines set forth in this Policy.
- Organ and Tissue Transplants:

a. Subject to the conditions described below, benefits for Covered Services and supplies provided to a Covered Person by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be determined as follows, but only if all the following conditions are met:

1) The transplant procedure is not Experimental/Investigational in nature; and
2) Donated human organs or tissue or an FDA-approved artificial device are used; and
3) The recipient is a Covered Person under the Policy; and
4) The transplant procedure is preauthorized as required under the Policy; and
5) The Covered Person meets all of the criteria established by BCBSTX in pertinent written medical policies; and
6) The Covered Person meets all of the protocols established by the Hospital in which the transplant is performed.

Covered Services and supplies "related to" an organ or tissue transplant include, but are not limited to, x-rays, laboratory testing, chemotherapy, radiation therapy, prescription drugs, procurement of organs or

tissues from a living or deceased donor, and complications arising from such transplant.

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

   Benefits will be available for:
   1) A recipient who is covered under this Policy; and
   2) A donor who is a Covered Person under this Policy; or
   3) A donor who is not a Covered Person under this Policy.

c. Covered Services and supplies include services and supplies provided for the:
   1) Donor search and acceptability testing of potential live donors; and
   2) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
   3) Removal of organs or tissues from living or deceased donors; and
   4) Transportation and short-term storage of donated organs or tissues.

d. No benefits are available for a Covered Person for the following services or supplies:
   1) Living and/or travel expenses of the recipient or a live donor;
   2) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
   3) Purchase of the organ or tissue; or
   4) Organs or tissue (xenograft) obtained from another species.

e. Preauthorization is required for any organ or tissue transplant. Review the Preauthorization Requirements section in this Policy for more specific information about Preauthorization.
   1) Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
   2) At the time of Preauthorization, BCBSTX will assign a length-of-stay for the admission. Upon request, the length-of-stay may be extended if BCBSTX determines that an extension is Medically Necessary.

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

- Treatment of Chemical Dependency: Benefits for Covered Expenses incurred for the treatment of Chemical Dependency will be the same as for treatment of any other sickness. Subject to the Preauthorization guidelines set forth in this Policy. Mental Health Care provided as part of the Medically Necessary treatment of Chemical Dependency will be considered for benefit purposes to be treatment of Chemical Dependency until completion of Chemical Dependency treatments. (Mental Health Care treatment after completion of Chemical Dependency treatments will be considered Mental Health Care.)
- Serious Mental Illness: Benefits for Covered Expenses incurred for the treatment of Serious Mental Illness will be the same as for treatment of any other sickness. Subject to the Preauthorization guidelines set forth in this Policy.
- Mental Health Care: Benefits for Covered Expenses incurred for the treatment of Mental Health Care will be the same as for treatment of any other sickness. Subject to the Preauthorization guidelines set forth in this Policy.
- Adult Vision Exam: Benefits for an annual routine adult vision exam, for age 19 and over, are covered subject to the same Deductibles, Coinsurance amounts, and Copayment amounts as for services and supplies generally.

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 a length of time determined by the attending Doctor to be Medically Necessary inpatient care for a minimum of:

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

The minimum number of inpatient hours is not required if the individual receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate. The length of time will be based on the evaluation of the patient and the availability of post-discharge doctor's office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

Benefits will be payable on the same basis as any other Sickness under the Policy. "Mastectomy" means the surgical removal of all or part of a breast.

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.

Breast Reconstructive Surgery after Mastectomy

Your contract as required by the federal Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. If a Covered Person is eligible for mastectomy benefits under this Policy and she elects breast reconstruction in connection with such mastectomy, she also is covered for the following:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for breast reconstructive surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the Policy definition of "Medically Necessary".

Benefits will be payable on the same basis as any other Sickness or Injury under the Policy, including the application of appropriate Deductibles and Coinsurance amounts.

Benefits for Certain Tests for Detection of Prostate Cancer

Benefits are available for an annual medically recognized diagnostic, physical examination for the detection of prostate cancer and a prostate-specific antigen test used for the detection of prostate cancer for each male under

the plan who is at least:

1. 50 years of age and asymptomatic; or
2. 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Diabetes Coverage and Self-Management Education

Benefits will be paid for Covered Expenses incurred by a Covered Person for Medically Necessary equipment and related supplies for the treatment of Type 1, Type 2, or gestational diabetes when prescribed by a Doctor or other licensed health care Provider

Benefits for such charges will be payable on the same basis as any other Sickness under the Policy.

Equipment and related supplies which may be Medically Necessary include, but are not limited to, the following:

- Blood glucose monitors, including blood glucose monitors for the visually impaired, noninvasive glucose monitors, and monitor test strips;
- Visual and urine testing strips and tablets, lancets and lancet devices, injection aids, and syringes;
- Biohazard disposal containers;
- Insulin and insulin analog preparations;
- Prescription drugs and medications available without prescription for the controlling of blood sugar levels;
- Insulin pumps, external and implantable, and equipment and supplies for the use of the pump including:
    - batteries;
    - insulin infusion devices and infusion sets;
    - insulin cartridges and durable and disposable devices for the injection of insulin; and
    - skin preparation items and adhesive supplies;
- Repairs and necessary maintenance of insulin pumps not otherwise provided by manufacturer's warranty or purchase agreement. This will include the rental fee for pumps during repair or necessary maintenance; however, such fees will not exceed the purchase price of a similar replacement pump;
- Podiatric appliances and therapeutic footwear; and
- Glucagon emergency kits.

Coverage is also provided for the regular foot care exams of a diabetic patient when provided by a Doctor.

All supplies, including medications and equipment for the control of diabetes will be dispensed as written, unless substitution is approved by the Doctor or health care Provider who issued the written order.

Benefits are payable on the same basis as any other covered Sickness under the Policy.

Benefits are payable for Covered Expenses incurred for a program of instruction in the self-care of diabetes that enables a diabetic to understand the disease and to manage its daily therapy when prescribed by a Doctor or other health care Provider.

Diabetes self-management training including medical nutritional therapy may be conducted individually or in a group; but it must be provided by a Doctor or certified, registered or licensed health care professional with expertise in diabetes. Coverage will include all educational materials for such program.

Diabetic self-management education benefits are payable to the same extent as any other covered Sickness and subject to all of the terms and conditions of the Policy.

Temporomandibular and Craniomandibular Joint Disorder Treatment Expense

Expenses for the Medically Necessary diagnosis or surgical treatment of temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD) as a result of an accident, a trauma, congenital defect, a developmental defect, or a pathology are covered to the same extent as any other skeletal disorder. Such expenses are subject to all provisions of the Policy that apply to any other Sickness.

Child Hearing Tests and Immunizations

Coverage is provided for a screening test for hearing loss for a child from the date of birth through the date the child is 30 days old and any necessary diagnostic follow-up care related to such screening test through the date the child is 24 months old.

Coverage is also provided for the vaccine and administration charges for the following immunizations: diphtheria, Haemophilus influenza type b (Hib), hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, and any other immunization that is required by law for the child.

Child immunizations will be provided for covered Dependents from the date of birth through age 6.

Benefits for immunizations will be subject to all of the terms and conditions of the Policy except that no Deductible, Copayment, or Coinsurance will apply.

Inheritable Metabolic Disorders

Coverage is provided for enteral formulas necessary for the treatment of Phenylketonuria or other inheritable metabolic disorders. Benefits are the same as provided for any other prescription drug and subject to all of the terms and conditions of the Policy.

Elemental Formulas

Coverage is provided under the group policy for the Covered Expenses incurred for amino acid-based elemental formulas. Such formulas must be upon written order of a Doctor and Medically Necessary for the diagnosis and treatment of:

- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
- severe food protein induced enterocolitis syndrome;
- eosinophilic disorders as evidenced by a biopsy; and
- impaired absorption of nutrients due to disorders of the gastrointestinal tract.

Coverage will also be provided for any Medically Necessary medical services associated with the administration of these formulas.

Benefits will be provided to the same extent as for any other covered medical services and subject to all of the terms and conditions of the group policy as apply to any other covered sickness.

Craniofacial Abnormalities

Coverage will include the Medically Necessary expenses incurred for reconstructive surgery for craniofacial abnormalities for a Covered Person.

“Reconstructive surgery for craniofacial abnormalities” means surgery to improve the function of or to attempt to create

a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or diseases.

Benefits are payable to the same extent and subject to all conditions and limitations of the Policy as apply to any other covered Sickness.

Telehealth and Telemedicine Services

Coverage is provided for expenses incurred for telehealth and telemedicine medical services as defined below.

"Telehealth Services" means a health service, other than a Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in Texas and acting within the scope of the health professional's license, certification, or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

"Telemedicine Medical Services" means a health care service delivered by a Physician licensed in Texas, or a health professional acting under the delegation and supervision of a Physician licensed in Texas state, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.

Benefits are payable to the same extent as for any other covered medical service and subject to all of the terms and conditions of the Policy.

Acquired Brain Injury

Coverage is provided for the following services necessary as a result of, and related to, an acquired brain injury:

- Cognitive rehabilitation therapy;
- Cognitive communication therapy;
- Neurocognitive therapy and rehabilitation;
- Neurobehavioral, 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.

Such services may be provided a Hospital, including an acute or post-acute rehabilitation hospital; or an assisted living facility as regulated by the state.

For purposes of this section, post-acute care will include coverage for the reasonable expenses related to periodic re-evaluation of the plan for a Covered Person with an acquired brain injury who:

- has been unresponsive to treatment; and
- becomes responsive at a later date.

Determination of whether such post-acute care expenses are reasonable will include consideration of factors including:

- cost;
- the time elapsed since the prior evaluation;
- differences in the expertise of the Provider performing the evaluation; and
- changes in technology and advances in medicine.

Benefits for acquired brain injury will not be subject to any visit limit indicated on your Benefit Highlights. For purposes of this provision, the following words and terms have these meanings:

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

"Cognitive communication therapy" means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

"Cognitive rehabilitation therapy" means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

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

"Neurobehavioral treatment" means interventions that focus on behavior and the variables that control behavior.

"Neurocognitive rehabilitation" means 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" means services designed to address neurological deficits in informational processing and to facilitate the development of higher level of cognitive abilities.

"Neurofeedback therapy" means services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

"Neurophysiological testing" is an evaluation of the functions of the nervous system. "Neurophysiological treatment" means interventions that focus on the functions of the nervous system.

"Neuropsychological testing" means 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" means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

"Outpatient day treatment services" means structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings

"Post-acute Care treatment services" means services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, This includes a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

"Post-acute transition services" means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

"Psychophysiological testing" is an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

"Psychophysiological treatment" means interventions designed to alleviate or decrease abnormal physiological responses

of the nervous system due to behavioral or emotional factors.

Benefits will be payable on the same basis as any other illness and subject to all provisions and limitations of the group policy.

Autism Spectrum Disorders

Coverage is provided under the group policy for Covered Expenses incurred for treatment of a covered child who has been diagnosed with Autism Spectrum Disorder. Treatment will include generally recognized services contained in a treatment plan recommended by the child's primary Doctor. Such services will include but are not limited to:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and management;
- speech, physical, and occupational therapy; and
- medications or nutritional supplements used to address symptoms of the autism spectrum disorder.

"Autism Spectrum Disorder" means a neurobiological disorder that includes autism. Asperger's syndrome, or other non-specific Pervasive Developmental disorders. "Neurobiological disorder" means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Benefits will be payable to the same extent as for covered medical expenses for any other covered illness and subject to all of the terms and conditions of the group policy not to the contrary.

Clinical Trial Programs

Coverage will be provided under the group health policy for those Covered Expenses incurred by a Covered Person participating in a Phase I, II, III or IV clinical trial program for the detection, prevention or treatment of cancer or a Life-Threatening Disease or Condition and is recognized under state and/or federal law.

Prosthetic and Orthotic Devices

Coverage is provided for Prosthetic Devices, Orthotic Devices and professional services related to the fitting and use of these devices.

Covered Services are limited to the most appropriate model of Prosthetic Device or Orthotic Device that adequately meets the medical needs of the Covered Person as determined by the Covered Person's treating Physician or Podiatrist and Prosthetist, or Orthotist, as applicable.

Coverage may be subject to annual Deductibles, Copayments and Coinsurance that are consistent with those for other coverage under this Policy and may not be subject to annual dollar maximums.

Cochlear Implants

One cochlear implant, which includes an external speech processor and controller, per impaired ear is covered. Coverage also includes related treatments such as Habilitation and Rehabilitation services, fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids. Implant components may be replaced as Medically Necessary or audiologically necessary.

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 certain orally administered anticancer medications. To determine if a specific drug is included in this benefit, a Covered Person may contact Customer Service at 1-855-267-0214.

Inpatient Stay Following Birth of a Child

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

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

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

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

If a covered mother or her newborn child is discharged before the 48 hour or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breastfeeding 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 for 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.

Preventive Care Services

Preventive care services will be provided for the following covered services:

a. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

b. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

c. evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and

d. with respect to women, such additional preventive care and screenings, not described in item a. above, as provided for in comprehensive guidelines supported by the HRSA.

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

The preventive care services described in items a. through d. may change as USPSTF, CDC and HRSA guidelines are modified. For more information, a Covered Person may access the website at www.bcbstx.com or contact customer service at 1-855-267-0214.

Examples of covered services included are routine annual physicals, immunizations, well-child care, cancer screening

mammograms, bone density test, colorectal cancer, smoking cessation counseling services and health diet counseling and obesity screening/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this benefit provision.

Preventive care services included in items a. through d. above provided by a Network Provider will not be subject to Coinsurance, Deductible, Copayment or dollar maximums.

Preventive care services included in items a. through d. above provided by an Out-of-Network Provider will be subject to Coinsurance and Deductibles. Deductibles and Coinsurance are not applicable to immunizations covered under the **Child Hearing Tests and Immunizations** provision**.**

Covered services not included in items a. through d. above may be subject to Coinsurance, Deductible, Copayment and/or dollar maximums.

If a recommendation or guideline for a particular preventive care service does not specify the frequency, method, treatment or setting in which it much be provided, BCBSTX may use reasonable medical management techniques to apply coverage.

If a covered preventive care service is provided during an office visit and is billed separately from the office visit, the Covered Person may be responsible for Coinsurance, Deductible and/or Copayments for the office visit only. If an office visit and the preventive care service are not billed separately and the primary purpose of the visit was not the preventive health service, the Covered Person may be responsible for Coinsurance, Deductible and/or Copayments.

Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

Benefits are available for certain tests for detection of Human Papillomavirus and Cervical Cancer for each woman enrolled in the plan who is 18 years of age or older for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the United States Food and Drug Admistration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Mammography Screening

Benefits are available for a screening by low-dose mammography for the presence of occult breast cancer for a Covered Person 35 years of age and older except that benefits will not be available for more than one routine mammography screening each calendar year. Low-dose mammography includes digital mammography or breast tomosynthesis.

Benefits for Detection and Prevention of Osteoporosis

If a Covered Person is a *Qualified Individual*, benefits are available for medically accepted bone mass measurement for the detection of low bone mass and to determine a Covered Person's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

a. A postmenopausal woman not receiving estrogen replacement therapy;

b. An individual with:

- vertebral abnormalities,

- primary hyperparathyroidism, or
- a history of bone fractures; or

c. An individual who is:

- receiving long-term glucocorticoid therapy, or
- being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits for Tests for Detection of Colorectal Cancer

Benefits are available for a diagnostic, medically recognized screening examination for the detection of colorectal cancer for Covered Persons who are 50 years of age or older and who are at normal risk for developing colon cancer:

- A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years; or
- A colonoscopy performed every ten years.

Benefits for Outpatient Contraceptive Drugs, Devices, and Procedures Not Subject to Coinsurance, Deductible, Copayment, or Benefit Maximum

Benefits will be provided to women with reproductive capacity for specified drugs and devices in each of the following categories of FDA approved contraceptive drugs and devices, including certain: progestin-only contraceptives; combination contraceptives; emergency contraceptives; extended-cycle/continuous oral contraceptives; cervical caps; diaphragms; implantable contraceptives; intra-uterine devices; injectables; transdermal contraceptives and vaginal contraceptive devices. The contraceptive drugs and devices listed above may change as FDA guidelines, medical management and medical policies are modified. NOTE: Prescription contraceptive medications are covered under the

Outpatient Prescription Drug Program portion of the plan.

Contact Customer Service at 1-855-267-0214 to determine what contraceptive drugs and devices are covered under this benefit provision.

Contraceptive drugs and devices not covered under this benefit provision may be covered under other sections of this certificate, subject to any applicable Coinsurance, Copayments, Deductibles and/or benefit maximum.

Benefits will be provided for female sterilization procedures for women with reproductive capacity and Outpatient Contraceptive Services benefits. Also, benefits will be provided for FDA approved over-the-counter female contraceptives with a written prescription by a Health Care Practitioner. The Covered Person will be responsible for submitting a claim form with the written prescription and itemized receipt for the female over-the-counter contraceptive. Visit the BCBSTX website at www.bcbstx.com to obtain a claim form.

Benefits for the above listed services received from Out-of-Network Providers or non-Participating Pharmacies may be subject to any applicable Deductible, Coinsurance, Copayment and/or benefit maximum.

Benefits for Breastfeeding Support, Services and Supplies

Benefits will be provided for breastfeeding counseling and support services when rendered by a Physician, during pregnancy and/or in the post-partum period. Benefits include the rental (or at the plan's option, the purchase) of manual or electric breast pumps, accessories and supplies. Limited benefits are also included for the rental only of hospital grade breast pumps. Covered Persons may be required to pay the full amount and submit a claim form to BCBSTX with a written prescription and the itemized receipt for the manual, electric or hospital grade breast pump, accessories and supplies. Visit the BCBSTX website www.bcbstx.com to obtain a claim form.

If the Covered Person uses an Out-of-Network Provider, the benefits may be subject to any applicable Deductible, Coinsurance, Copayment and/or benefit maximum. Contact Customer Service at 1-855-267-0214 for additional info

Outpatient Prescription Drug Program

- Prior Authorization: Certain Prescription Drugs require a drug's prescribed use to be evaluated against a predetermined set of criteria to determine Medical Necessity before the prescription will be covered. If the approval is not granted, the Covered Person may appeal the decision.
- Copayment amounts: Copayment amounts for a Participating Pharmacy or non- Participating Pharmacy are shown on your Schedule of Coverage. The amount you pay depends on the Covered Drug dispensed. If the Allowable Amount of the Covered Drug is less than the Copayment Amount, the Participant will pay the lower cost. When that lower cost is more than the amount you would pay if you purchased the drug without using your BCBSTX pharmacy benefits or any other source of drug benefits or discounts, you pay such purchase price.
- Step Therapy: When the Covered Person buys a Prescription Drug which has a more cost effective option in the same therapeutic class and recommended by the Pharmacist, coverage will be limited to the cost of the more cost effective drug.
- Step Therapy Exception Requests: Step Therapy Exception Request: Your prescribing Physician or other Health Care Practitioner may submit a written request for an exception to the Step Therapy requirements. The Step Therapy Exception Request will be considered approved if we do not deny the request within 72 hours after receipt of the request. If your prescribing Physician or other Health Care Practitioner reasonably believes that denial of the Step Therapy Exception Request could cause you serious harm or death, submission of the request with Urgent noted and documenting these concerns will be considered approved if we do not deny the request within 24 hours after receipt of the request. If your Step Therapy Exception Request is denied, you have the right to request an expedited internal appeal and also have the right to request review by an Independent Review Organization as explained in the CLAIM PROVISIONS section of this Policy.
- Prescription Refills. You may obtain prescription drug refills from any Participating Pharmacy. Once every 12 months, you will be able to synchronize the start time of certain Covered Drugs used for treatment and management of a chronic illness so they are refilled on the same schedule for a given time period. When necessary to fill a partial Prescription Order to permit synchronization, Blue Cross Blue Shield will prorate the Copayment due for Covered Drugs based on the proportion of days the reduced Prescription Order covers to the regular day supply outlined in the Schedule of Benefits for Outpatient Prescription Drugs.
  Refills for prescription eye drops to treat a chronic eye drops to treat a chronic eye disease or condition will be refilled if (1) the original Prescription Order states that additional quantities of the eye drops are needed; (2) the refill does not exceed the total quantity of dosage units authorized by the prescribing Health Care Practitioner on the original Prescription Order, including refills; and (3) the refill is dispensed on or before the last day of the prescribed dosage period. The refills are allowed:
  - not earlier than the 21st day after the date a Prescription Order for a 30-day supply is dispensed; or
  - not earlier than the 42nd day after the date a Prescription Order for a 60-day supply is dispensed; or
  - not earlier than the 63rd day after the date a Prescription Order for a 90-day supply is dispensed.
- Dispensing Limits: If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Health Care Practitioner, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Dispensing limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.
- Controlled Substance Limitation: If Blue Cross and Blue Shield determines that a Covered Person may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any coverage for additional drugs may be subject to a review for

Medical Necessity, appropriateness and other coverage restrictions such as limiting coverage to Prescription Orders written by a certain Provider and/or dispensed by a certain Network Pharmacy.

- Out-of-Network Pharmacies: When a Covered Person obtains Prescription Drugs, including diabetic supplies from an Out-of-Network Pharmacy (other than a Network Pharmacy), benefits will be provided at 60% of the amount a Covered Person would have received had he/she obtained drugs from a Network Pharmacy minus the Copayment amount or Coinsurance amount. Covered Persons will be responsible for the difference between the Allowable Amount and the billed charges, when receiving Prescription Drugs from and Out-of-Network Pharmacy.
- Specialty Drugs: In order to receive maximum benefits for Specialty Drugs, a Covered Person must obtain the Specialty Drugs from the preferred Specialty Pharmacy Provider.

Drug List

A Preferred Brand Name Drug is subject to the Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive. These drugs are identified on the Preferred Drug List that is maintained by BCBSTX. 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.

BCBSTX will routinely review the Drug List and periodically adjust it to modify the Preferred or Non-Preferred Brand Name Drug status of existing or new drugs. Changes to this list will be implemented on the Covered Person's anniversary date. The Drug List and any modifications will be made available to Covered Persons. We will provide you notification of any change to coverage under the Plan sixty (60) days before the modification is effective. You may access Our website at www.bcbstx.com or call Customer Service at 1-855-267-0214 to determine if a particular drug is on the Preferred Drug List. Drugs that do not appear on the Drug List are subject to the Non-Preferred Brand Name Drug Copayment Amount plus any pricing differences that may apply to the Covered Drug you receive.

Drug List Exception Requests

You, or your Physician or Health Care Practitioner with prescriptive authority, can ask for a Drug List exception if your drug is not on the Drug List (also known as a formulary). To request this exemption, you, your prescribing Physician or other Health Care Practitioner, can call the number on the back of your ID card to ask for a review. You may be required to submit a supporting statement from your prescribing Physician or other Health Care Practitioner.

If you have a health condition that may jeopardize your life, health, your ability to regain maximum function or you are undergoing a current course of treatment using a drug that is not on the Drug List, an expedited review may be requested. You, your prescribing Physician or other Health Care Practitioner, will be notified of the coverage decision within 24 hours after the request for expedited review is received. If your request is granted, coverage will be provided for the duration of the exigency.

For requests that do not meet the criteria for expedited review, a standard review will be completed and you and your prescribing Physician or other Health Care Practitioner will be notified of the coverage decision within 72 hours after the request for standard review is received. If your request is granted, coverage will be provided for the duration of the prescription, including refills.

If your expedited or standard Drug List exception request is denied, the decision notice will include information explaining Your right to request review by an Independent Review Organization. You and your prescribing physician or other Health Care Practitioner will be notified of the IRO's decision within 24 hours for an expedited review and within 72 hours for a standard review. If your expedited exception request is granted, coverage will be provided for the duration of the exigency. If your standard exception request is granted, coverage will be provided for the duration of the prescription, including refills.

Injectable Drugs

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

Diabetic Supplies for Treatment of Diabetes

Benefits are available for Medically Necessary items of diabetic supplies for which a Health Care Practitioner has written an order. Such diabetes supplies shall include, but are not limited to, the following:

- Test strips specified for use with a corresponding blood glucose monitor
- Glucose test solutions
- Glucagon
- Glucose tablets
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels
- Glucagon emergency kits
-

All supplies, including medications and equipment for the control of diabetes will be dispensed as written, unless substitution is approved by your prescribing Physician or other Health Care Practitioner who issues the written order for the supplies or equipment.

Vaccinations obtained through Network Pharmacies

Benefits for vaccinations are available through certain Network Pharmacies that have contracted with Blue Cross and Blue Shield to provide this service. To locate one of these contracting Network Pharmacies in a Student's area and to find out which vaccinations are covered, they can call Customer Service at 1-855-267-0214 or access the website at *www.bcbstx.com*.

Each Network Pharmacy that has contracted with Blue Cross and Blue Shield to provide this service may have age, scheduling, or other requirements that will apply, so Covered Persons are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under the Outpatient Prescription Drug Program. A Covered Person can refer to his/her Blue Cross and Blue Shield medical coverage for benefits available for childhood immunizations.

Benefits for vaccinations that are considered preventive care services will not be subject to any Deductible,

Coinsurance, Copayment or dollar maximum when such services are received from a Network Provider or Network Pharmacy that is contracted for such service.

Vaccinations that are received from an Out-of-Network Provider or from a Non-Plan Provider facility or Out-of-Network Pharmacists, or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance, Copayments and/or benefit maximums.

Acne medication
Benefits are available to Covered Persons for the treatment of acne and are limited to Generic Drugs only.

Pediatric Vision Care

This *Pediatric Vision Care Section* is made part of, and is in addition to any information a Policyholder may have in this Policy. This *Pediatric Vision Care Section* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under a Covered Person's medical/surgical benefits of this Policy. **(Services that are covered under a Covered Person's medical/surgical benefits of this Policy are not covered under this *Pediatric Vision Care Section*.) All provisions in this Policy apply to this *Pediatric Vision Care Section* unless specifically indicated otherwise below.**

This BCBSTX vision care plan allows Covered Persons to select the Provider of their choice, in or out of the Network. BCBSTX has designed benefit plans to deliver quality care, matched with comprehensive benefits, at the most affordable cost, through Network services. Covered Persons will have a higher benefit level if they choose to receive Pediatric Vision Care services from a Network Provider.

Definitions

Benefit Period – For purposes of this *Pediatric Vision Care Section*, a period of time that begins on the later of: 1) the Covered Person's Effective Date of coverage under this Pediatric Vision Care Section, or 2) the last date a vision examination was performed on the Covered Person or that Vision Materials were provided to the Covered Person, whichever is applicable. (A benefit period does not coincide with a calendar year and may differ for each Covered Person of a group or family.)

Provider – For purposes of this *Pediatric Vision Care Section*, a licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician.

Vision Materials – Corrective lenses and/or frames or contact lenses.

Eligibility

Children who are covered under this Policy's medical/surgical benefits, up to age 19, are eligible for coverage under this *Pediatric Vision Care Section*. NOTE: Once coverage is lost under the medical/surgical benefits of this Policy, all benefits cease under this *Pediatric Vision Care Section*. Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available under this *Pediatric Vision Care Section*.

Limitations and Exclusions

In addition to the general limitations and exclusions listed in this Policy, this *Pediatric Vision Care Section* does not cover services or materials connected with or charges arising from:

- any vision service, treatment or materials not specifically listed as a covered service
- services and materials not meeting accepted standards of optometric practice

- services and materials resulting from a Covered Person's failure to comply with professionally prescribed treatment
- services rendered after the date an Insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order
- telephone consultations
- any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances
- office injection control charges
- charges for copies of Covered Person's records, charts, or any costs associated with forwarding/mailing copies of Covered Person's records or charts
- state or territorial taxes on vision services performed
- medical treatment of eye disease or injury
- visual therapy
- special lens designs or coatings other than those described in this section
- replacement of lost/stolen eyewear
- non-prescription (Plano) lenses
- non-prescription sunglasses
- two pairs of eyeglasses in lieu of bifocals
- services not performed by licensed personnel
- prosthetic devices and services
- insurance of contact lenses
- professional services a Covered Person receives from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption
- services covered under the medical/surgical benefits of this Policy
- replacement of lost, stolen, damaged, or broken materials, until the next Benefit Frequency when Vision Materials would next become available.
- services of unlicensed personnel
- Orthoptic or vision training; Aniseikonic spectacle lenses
- Any eye or Vision Examination, or any corrective eyewear required by Policyholder as a condition of employment or safety eyewear.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency program whether federal, state, or subdivisions thereof.

How the Vision Care Plan Works

Under the vision care plan option, a Covered Person may visit any covered Provider and receive benefits for a vision examination. In order to maximize benefits for most covered Vision Materials, however, a Covered Person must purchase them from a Network Provider.

Before a Covered Person goes to a Network vision care plan Provider for an eye examination, eyeglasses, or contact lenses, he/she should call ahead for an appointment. When a Covered Person arrives, he/she should show the receptionist their Identification Card. If a Covered Person forgets to take their card, he/she should say that he/she is a member of the BCBSTX vision care plan so that his/her eligibility can be verified.

To locate a Network vision care Provider, Covered Persons can visit Our website at **www.bcbstx.com**, or Students can contact Customer Service at 1-855-267-0214 to obtain a list of the Network vision care plan Providers nearest them.

If a Covered Person obtain glasses or contacts from an Out-of-Network Provider, he/she must pay the Provider in full and submit a claim for reimbursement (Covered Persons should see the **CLAIM PROVISIONS** section of this Policy for more information).

A Covered Person may receive his/her eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Network Provider and there may be additional professional charges if a Covered Person seeks contact lenses from a Provider other than the one who performed his/her eye examination.

Fees charged for services other than a covered vision examination or covered Vision Materials, and amounts in excess of those payable under this *Pediatric Vision Care Section*, must be paid in full by the Covered Person to the Provider, whether or not the Provider participates in the vision care plan network. Benefits under this *Pediatric Vision Care Section* may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

Schedule of Pediatric Vision Coverage

Vision Care Services	**In-NetworkCovered Person Cost** (When a fixed-dollar copayment is due from the Covered Person, the remainder is payable by the Policy up to the covered charge*)	**Out-of-Network Allowance** (maximum amount payable by the Policy, not to exceed the retail cost)**
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
Any available frame at provider location	No Copayment on provider-designated frame; $150 allowance on non-provider designated frame.	Up to $75
Standard Plastic Lenses:		
Single Vision Bifocal Trifocal Lenticular	No Copayment No Copayment No Copayment No Copayment	$25 $40 $55 $55
Lens Options:		

UV Treatment	No Copayment	$12
Tint (Fashion & Gradient & Glass-Grey)	No Copayment	$12
Standard Plastic Scratch Coating	No Copayment	$12
Standard Polycarbonate	No Copayment	$32
Glass	No Copayment	$12
Oversized	No Copayment	$12
Contact Lenses: *(Contact Lens allowance includes materials only)*		
Conventional	No Copayment; $150 allowance 15% off balance over $150	$150
Disposable	No Copayment; $150 allowance, plus balance over $150	$150
Medically Necessary *Note: In some instances, Participating Providers may charge separately for the evaluation, fitting, or follow- up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, a Covered Person may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance).*	No Copayment, Paid-in-Full	$210

Frequency:	
Examinations, Lenses, or Contact Lenses	Once every Benefit Period
Frame	Once every Benefit Period
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.	
Value-addedfeatures: **Laser vision correction:** A Covered Person will receive a discount for traditional LASIK and custom LASIK from participating Physicians and affiliated laser centers. *Prices/discounts may vary by state and are subject to change without notice.*	
AdditionalBenefits	

Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions:

Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary preauthorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Our Covered Persons with low vision. Covered low vision services (both In- and Out-of-Network) will include one comprehensive low vision evaluation every 5 years; items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period. Participating Providers will obtain the necessary preauthorization for these services.

Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Covered Persons should ask their Provider for details of the warranty that is available to them.

Note: Additional discounts on materials may be available.

*The "covered charge" is the rate negotiated with Network Providers for a particular covered service.

**The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

Exclusions and Limitations

Except as specified in this Policy, coverage is not provided for loss or charges incurred by or resulting from:

- charges that are not Medically Necessary or in excess of the Allowable Amount;
- services that are provided, normally without charge, by the Student Health Center, infirmary or Hospital, or by any person employed by the University;
- acupuncture procedures;
- bio-feedback procedures, except as needed to treat acquired brain injuries;
- breast augmentation or reduction;
- routine circumcision, unless the procedure is Medically Necessary for treatment of a sickness, disease or functional congenital disorder not excluded hereunder or as may be necessitated due to an Accident or except for covered infants within 28 days of birth;
- non-malignant warts;
- moles;
- lesions;
- testing or treatment for sleep disorders;
- any charges for Surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are Experimental or Investigational;
- expenses incurred for Injury or Sickness arising out of or in the course of a Covered Person's employment, regardless if benefits are, or could be paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
- treatment, services or supplies in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment;
- Expenses in connection with services and prescriptions for, eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses; radial keratotomy; or laser surgery for vision correction or the treatment of visual defects or problems, except for pediatric vision;
- sinus or other nasal surgery, including correction of a deviated septum by submucous resection and/or other surgical correction, except for a covered Injury;
- reconstructive Surgery, plastic Surgery, cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore a Covered Person's appearance, unless:

- needed to repair conditions resulting from an accidental Injury; or
- for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.
- for the treatment provided for reconstructive surgery following cancer surgery.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.

- riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;
- war, or any act of war, whether declared or undeclared or while in service in the active or reserve Armed Forces of any country or international authority;
- any expenses incurred in connection with sterilization reversal or vasectomy reversal;
- in-vitro fertilization;
- promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-

peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer;

- donor expenses for a Covered Person in connection with an organ and tissue transplant if the recipient is not covered under this Policy;
- expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to Covered Oral Surgery or the repair of Injuries to sound natural teeth caused by a covered Injury;
- Foot care, including: flat-foot conditions, subluxations, care of corns, bunions (except: capsular or bone surgery), calluses, toenails, fallen arches, weak feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency;
- hirsutism;
- alopecia;
- gynecomastia;
- weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind;
- surgery for the removal of excess skin or fat;
- nutrition programs, except as related to treatment for diabetes;
- Custodial Care;
- long term care service;
- bariatric surgery;
- private duty nursing services;
- weight loss programs;
- prescription drug coverage is not provided for:
    - refills in excess of the number specified or dispensed after one (1) year from the date of the prescription;
    - drugs labeled "Caution - limited by federal law to investigational use" or experimental drugs;
    - immunizing agents, biological sera, blood or blood products administered on an Outpatient basis, except as specifically provided in this Policy;
    - any devices, appliances, support garments, hypodermic needles except as used in the administration of insulin, or non-medical substances regardless of their intended use;
    - drugs used for cosmetic purposes, including but not limited to Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control, etc;
    - fertility agents or sexual enhancement drugs, medications or supplies for the treatment of impotence and/or sexual dysfunction, including but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra;
    - lost or stolen prescriptions;
    - drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control;
    - nonsedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant;
    - non-commercially available compounded medications, regardless of whether or not one or more ingredients in the compound requires a Prescription Order. (Non-commercially available compounded medications are those made by mixing or reconstituting ingredients in a manner or ratio that is inconsistent with United States Food and Drug Administration-approved indications provided by the ingredients' manufacturers.)
    - Brand Name proton pump inhibitors;
    - drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular

use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.

NON-DUPLICATION OF BENEFITS LIMITATION

If benefits are payable under more than one (1) benefit provision contained in the Policy, benefits will be payable only under the provision providing the greater benefit.

Coordination of Benefits

Coordination of Benefits ("COB") applies when you have health care coverage through more than one Health Care Plan. The order of benefit determination rules govern the order in which each Health Care Plan will pay a claim for benefits. The Health Care Plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The Health Care Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total Allowable Expense.

For purposes of this section only, the following words and phrases have the following meanings:

Allowable Expense means a health care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Health Care Plan covering the person for whom claim is made. When a Health Care Plan (including this Health Care Plan) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable Expense and a benefit paid. In addition, any expense that a health care provider or Physician by law or in accord with a contractual agreement is prohibited from charging a Covered Person is not an allowable expense.

Health Care Plan means any of the following (including this Health Care Plan) that provide benefits or services for, or by reason of, medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

Group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

Health Care Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long-term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

BCBSTX has the right to coordinate benefits between this Health Care Plan and any other Health Care Plan covering you.

The rules establishing the order of benefit determination between this Plan and any other Health Care Plan covering

you on whose behalf a claim is made are as follows:

1. The benefits of a Health Care Plan that does not have a Coordination of Benefits provision shall in all cases be determined before the benefits of this Plan.
2. If according to the rules set forth below in this section the benefits of another Health Care Plan that contains a provision coordinating its benefits with this Health Care Plan would be determined before the benefits of this Health Care Plan have been determined, the benefits of the other Health Care Plan will be considered before the determination of benefits under this Health Care Plan.

The order of benefits for your claim relating to **paragraphs 1 and 2** above, is determined using the first of the following rules that applies:

1. **Nondependent or Dependent.** The Health Care Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the Health Care Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Health Care Plan covering the person as a dependent and primary to the Health Care Plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the Health Care Plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Health Care Plan is the primary plan. An example includes a retired employee.
2. **Dependent Child Covered Under More Than One Health Care Plan.** Unless there is a court order stating otherwise. Health Care Plans covering a Dependent child must determine the order of benefits using the following rules that apply.
    a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
        (i) The Health Care Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
        (ii) If both parents have the same birthday, the Health Care Plan that has covered the parent the longest is the primary plan.
    b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
        (i) if a court order states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Health Care Plan of that parent has actual knowledge of those terms, that Health Care Plan is primary. This rule applies to plan years commencing after the Health Care Plan is given notice of the court decree.
        (ii) if a court order states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 2a must determine the order of benefits.
        (iii) if a court order states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 2a must determine the order of benefits.
        (iv) if there is no court order allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            (I) the Health Care Plan covering the custodial parent;
            (II) the Health Care Plan covering the spouse of the custodial parent;
            (III) the Health Care Plan covering the noncustodial parent; then
            (IV) the Health Care Plan covering the spouse of the noncustodial parent.
    c. For a Dependent child covered under more than one Health Care Plan of individuals who are not the parents of the child, the provisions of 2a or 2b must determine the order of benefits as if those individuals were the parents of the child.

d. For a Dependent child who has coverage under either or both parents' Health Care Plans and has his or her own coverage as a Dependent under a spouse's Health Care Plan, paragraph 5, below applies.
e. In the event the Dependent child's coverage under the spouse's Health Care Plan began on the same date as the Dependent child's coverage under either or both parents' Health Care Plans, the order of benefits must be determined by applying the birthday rule in 2a to the Dependent child's parent(s) and the Dependent(s) spouse.

3. Active, Retired, or Laid-Off Employee. The Health Care Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Health Care Plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the Health Care Plan that covers the same person is as a retired or laid-off employee or as a Dependent of a retired or laid-off employee does not have this rule, and as a result, the Health Care Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1, above can determine the order of benefits.
4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Health Care Plan, the Health Care Plan covering the person as an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Health Care Plan does not have this rule, and as a result, the Health Care Plans so not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1, above can determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The Health Care Plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the Health Care Plan that has covered the person the shorter period is the secondary plan.
6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the Health Care Plans meeting the definition of Health Care Plan. In addition, this Health Care Plan will not pay more than it would have paid had it been the primary plan.

When this Health Care Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Health Care Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Health Care Plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Health Care Plans for the claim equal 100 percent of the total Allowable Expense for that claim. In addition, the secondary plan must credit to its plan deductible (if applicable) any amounts it would have credited to its deductible in the absence of other health care coverage.

If a Covered Person is enrolled in two or more closed panel Health Care Plans and if, for any reason, including the provision of service by a nonpanel provider, benefits are not payable by one closed panel Health Care Plan. COB must not apply between that Health Care Plan and other closed panel Health Care Plans.

When benefits are available to you as primary benefits under Medicare, those benefits will be determined first and benefits under this Plan may be reduced accordingly. You must complete and submit consents, releases, assignments and other documents requested by BCBSTX to obtain or assure reimbursement by Medicare.

For purposes of this provision, BCBSTX may, subject to applicable confidentiality requirements set forth in this Plan, release to or obtain from any insurance company or other organization necessary information under this provision. If you claim benefits under this Plan, you must furnish all information deemed necessary by Us to implement this provision.

None of the above rules as to Coordination of Benefits shall delay your health services covered under this Plan.

Whenever payments have been made by BCBSTX with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Part, We shall have the right to recover such payment, to the extent of such excess, from among, one or more of the following as We shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

Claim Provisions

Notice of Claim: Written (or authorized electronic or telephonic) notice of a claim under the Policy must be given to the Insurer or the Administrator within 20 days after any loss covered by the Policy occurs, or as soon thereafter as is reasonably possible. The notice should identify the Covered Person and the Policy number.

Claim Forms: Upon receipt of a written notice of claim, the Insurer or Administrator will send claim forms to the claimant within 15 days. If the forms are not furnished within 15 days, the claimant will satisfy the Proof of Loss requirements of the Policy by submitting written proof describing the occurrence, nature and extent of the loss for which claim is made.

Proofs of Loss: Written (or authorized electronic or telephonic) proof of loss must be furnished to the Insurer or its Administrator within 90 days after the date of loss. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided:

- it was not reasonably possible to provide proof in that time; and
- the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity.

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

Time for Payment of Claim: Benefits payable under the Policy will be paid immediately upon receipt of satisfactory written proof of loss.

Payment of Claims

All benefits will be payable to the Provider as soon as the Insurer receives due written proof of loss. Within 15 days after receipt of the proof of loss, the Insurer will either: (a) pay the benefits due; or (b) mail the Covered Person a statement of the reasons why the claim has, in whole or in part, not been paid. Such a statement will also list any documents or information that the Insurer needs to process the claim or that part of the claim not paid. When all of the listed documents or information are received, the Insurer will have 15 work days in which to: (a) process and either pay the claim, in whole or in part, or deny it; and (b) give the Covered Person the reasons the Insurer may have for denying the claim or any part of it. If the Insurer is unable to accept or reject the claim within this 15 work day period, the Insurer will notify the Covered Person of the reason for the delay. The Insurer will have 45 additional days to accept or reject the claim.

In the event that the Insurer does not comply with its obligations under this Payment of Claims provision, the Insurer will pay the interest at a rate required by law on the proceeds or benefits due under the terms of the Policy.

All benefits are payable to the Covered Person, except that:

- If the Covered Person receives medical assistance from the State of Texas, the Insurer will pay any benefits based on his or her medical expenses to the Texas Department of Human Services, but not more than the actual cost that the Department pays for those expenses. Only the balance, if any, of such benefits will then be payable to the Covered Person.
- All benefits paid on behalf of a dependent child under the Policy must be paid to the Texas Department of Human Services whenever: (a) the Texas Department of Human Services is paying benefits pursuant to the Human Resource Code; and (b) the parent who is covered by the Policy has possession

or access to the child pursuant to a court order or is not entitled to access or possession of the child and is required by the court to pay child support.

- If the Insured is not the custodial parent of the dependent child covered by the Policy, benefits may be Payable to the non-plan covered parent, provided that the following information is submitted to the Insurer: (a) written notice that the non-plan covered parent is the custodial parent of the dependent child; and (b) a certified copy of a court order designating the non-plan covered parent as the custodial parent (or other evidence designated by rule of the State Board of Insurance); and (c) a fully completed claim form. These requirements will not apply if a valid assignment of benefits for an unpaid medical bill has been made or if the Insured has paid a portion of the medical bill and files a claim.
- If the Covered Person is unable to execute a valid release, the Insurer can: (a) pay any Providers on whose charges the claim is based toward the satisfaction of those charges; or (b) pay any person or institution that has assumed custody and principal support of the Covered Person.
- If the Covered Person dies while any accrued benefits remain unpaid, the Insurer can pay any Provider on whose charges the claim is based toward the satisfaction of those charges. Then, any benefits that still remain unpaid can be paid to the Covered Person's beneficiary or estate.

The Insurer will be discharged to the extent of any such payments made in good faith.

Payment to Possessory or Managing Conservator of Dependent Child

For a minor child who otherwise qualifies as a Dependent of the insured Student, benefits may be paid on behalf of the child to a person who is not the insured Student if an order issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.

To be entitled to receive benefits, a possessory or managing conservator of a child must submit, to the Insurer, with the claim form, written notice that such person is the possessory or managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as the possessory or managing conservator. This will not apply in the case of any unpaid medical bills for which a valid assignment of benefits has been exercised or to claims submitted by the insured Student where the insured Student had paid any portion of a medical bill that would be covered under terms of the Policy.

REVIEW OF CLAIM DETERMINATIONS:

Claim Determinations

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

Note: If BCBSTX is seeking to discontinue coverage of prescription drugs or intravenous infusions for which you are receiving health benefits under this Policy, you will be notified no later than the 30th day before the date on which coverage will be discontinued.

If a Claim Is Denied or Not Paid in Full

On occasion, BCBSTX may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by BCBSTX; then review this Policy to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to BCBSTX and request a review of the decision as described in Claim Appeal

Procedures below.

If the claim is denied in whole or in part, you will receive a written notice from BCBSTX with the following information, if applicable:

- The reasons for determination;
- The professional specialty of the Physician who made the determination;
- A reference to the benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our internal review/appeals processes and how to initiate a review/appeal;
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- An explanation of your right, if applicable, to request review by an Independent Review Organization (IRO), at the expense of BCBSTX, including the request form;
- In the case of a denial of an urgent care clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care clinical claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification;
- In life-threatening, circumstances or if BCBSTX has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under the Plan, you are entitled to an immediate appeal to an IRO and are not required to comply with BCBSTX's appeal of an Adverse Determination process; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

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

1. **Urgent Care Clinical Claim** is any pre-service claim for benefits for medical care or treatment with respect to which the application of regular time periods for making a health claim determination could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

2. **Pre-Service Claim** is any non-urgent request for benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

3. **Post-Service Claim** is notification in a form acceptable to BCBSTX that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which BCBSTX may request in connection with services rendered to you.

Urgent Care Clinical Claims*

Type of Notice or Extension	Timing
If your claim involves post-stabilization treatment subsequent to emergency treatment or a life-threatening condition, BCBSTX will issue and transmit a determination indicating whether proposed services are preauthorized within:	The time appropriate to the circumstances relating to the delivery of the services and Your condition, but in no case to exceed one hour.
If your claim is incomplete, BCBSTX must notify you of any additional information needed to complete Your claim within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide the additional information to BCBSTX within:	**48 hours** after receiving notice
BCBSTX must notify you of the claim determination (whether adverse or not):	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
if the initial claim is incomplete, within:	**48 hours** after the earlier of our receipt of the additional information or the end of the period within which the additional information was to be provided

* If the request is received outside the period during which BCBSTX are required to have personnel available to provide determinations, BCBSTX will make the determination within one hour from the

beginning of the next time period requiring appropriate personnel to be available. You do not need to submit Urgent Care Clinical Claims in writing. You should call BCBSTX at the toll-free number listed on the back of your Identification Card as soon as possible to submit an Urgent Care Clinical Claim.

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

Pre-Service Claims

Type of Notice	Timing
BCBSTX must notify you of the claim determination (whether adverse or not):	
if BCBSTX has received all information necessary to complete the review, within:	**2 working days of or our receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and 3 calendar days of the request, if the claim is denied.**

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

Post-Service Claims (Retrospective Review)

Type of Notice or Extension	Timing
If your claim is incomplete, BCBSTX must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX within:	**45 days** after receiving notice
BCBSTX must notify you of any adverse claim determination:	
if the initial claim is complete, within:	**30 days after receipt of the claim**
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days, if we extended the period, less any days already utilized by BCBSTX during our review***

* This period may be extended one time by BCBSTX for up to 15 days, provided that we both (1) determine that such an extension is necessary due to matters beyond the control of the Plan and (2) notify you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which BCBSTX expect to render a decision. If the period is extended because BCBSTX requires additional information from you or your Provider, the period for our making the determination is tolled from the date BCBSTX sends notice of extension to you until the earlier of: i)

the date on which we receive the information; or ii) the date by which the information was to be submitted.

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

Claim Appeal Procedures

Claim Appeal Procedures - Definitions

An "Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit in response to a Claim, Pre-Service Claim or Urgent Care Claim, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

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

Expedited Clinical Appeals

If your situation meets the definition of an expedited clinical appeal, you may be entitled to an appeal on an expedited basis. An expedited clinical appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care provider, the denial of emergency care or continued hospitalization, the denial of a Step Therapy exception request, or the discontinuance by BCBSTX of prescription drugs or intravenous infusions for which you were receiving health benefits under this Policy. Before authorization of benefits for an approved ongoing course of treatment/continued hospitalization is terminated or reduced, BCBSTX will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process.

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

How to Appeal an Adverse Benefit Determination

You have the right to seek and obtain a review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your Policy.

An appeal of an Adverse Benefit Determination may be requested orally or in writing by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of

information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call BCBSTX at the number on the back of your ID card.

Your appeal will be acknowledged within five business days of the date BCBSTX receives it. The acknowledgment will include additional information concerning the appeal procedures and identify any additional documents that you must submit for review. If your appeal is made orally, BCBSTX will send you a one-page appeal form.

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

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

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

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

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

During the course of your internal appeal(s), BCBSTX will provide you or your authorized representative (free of charge) with any new or additional evidence considered, relied upon or generated by BCBSTX in connection with the appealed claim, as well as any new or additional rationale for a denial at the internal appeals stage. Such new or additional evidence or rationale will be provided to you or your authorized representative as soon as possible and sufficiently in advance of the date a final decision on appeal is made in order to give you a reasonable opportunity to respond. BCBSTX may extend the time period described in this Policy for its final decision on appeal to provide you with a reasonable opportunity to respond to such new or additional evidence or rationale. If the initial benefit determination regarding the claim is based in whole or in part on a medical judgment, the appeal determination will be made by a Physician associated or contracted with BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your claim. No deference will be given to the initial Adverse Benefit Determination. Before you or your authorized representative may bring any action to recover benefits, the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by BCBSTX.

- If you have any questions about the claims procedures or the review procedure, write to our Administrative Office or call customer service at the toll-free number on the back of your Identification Card.

Timing of Appeal Determinations

BCBSTX will render a determination on non-urgent concurrent, pre-service appeals that do not require

expedited review or preauthorization and post-service appeals as soon as practical, but in no event later than 30 days after the appeal has been received by us.

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

Notice of Appeal Determination

BCBSTX will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to you and your authorized representative will include:

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

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

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)

An "Adverse Determination" means a determination by BCBSTX or our designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, is determined to be experimental or investigational, or does not meet our requirement for medical necessity, appropriateness,

health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

This procedure (not part of the Complaint process) pertains only to appeals of Adverse Determinations. In addition, in life-threatening, urgent care circumstances, or if BCBSTX has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under this Policy, you are entitled to an immediate appeal to an IRO and are not required to comply with our appeal of an Adverse Determination process.

Any party whose appeal of an Adverse Determination is denied by BCBSTX may seek review of the decision by an IRO. BCBSTX will pay the cost of the IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative or Provider of record, information on how to appeal the denial, including the approved form, which you, your designated representative, or your Provider of record must complete. In life- threatening, urgent care situations, the denial of a Step Therapy exception request, or if BCBSTX has discontinued coverage of prescription drugs or intravenous infusions for which you were receiving health benefits under this Policy, you, your designated representative, or your Provider of record may contact BCBSTX by telephone to request the review and provide the required information. For all other situations, you or your designated representative must sign the form and return to BCBSTX to begin the independent review process.

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

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

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

The appeal process does not prohibit you from pursuing other appropriate remedies, including: civil action, injunctive relief; a declaratory judgment or other relief available under law.

Assignment: At the request of the Covered Person or his or her parent or guardian, medical benefits may be paid to the Provider of service. No assignment of benefits will be binding on the Insurer until a copy of the assignment has been received by the Insurer or its Administrator. The Insurer assumes no responsibility for the validity of the assignment. Any payment made in good faith will end Our liability to the extent of the payment.

Physical Examination and Autopsy: We have the right to have a Doctor of Our choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while benefits are being paid. We also have the right to request an autopsy in the case of death, unless the law forbids it. Such examinations or autopsy will be at the expense of the Insurer.

Subrogation: We may recover any benefits paid under the Policy to the extent a Covered Person is paid for the same Injury or Sickness by a third party, another insurer, or the Covered Person's uninsured motorist insurance. Our reimbursement may not be greater than the amount of the Covered Person's recovery. In addition, We have the right to offset future benefits payable to the Covered Person under the Policy against such recovery.

We may file a lien in a Covered Person's action against the third party and have a lien against any recovery that the Covered Person receives whether by settlement, judgment, or otherwise. We shall have a right to recovery of the full amount of benefits paid under the Policy for the Injury or Sickness, and that amount shall be deducted first from any recovery made by the Covered Person. We will not be responsible for the Covered Person's attorney fees or other costs.

Right of Recovery: If We make payments with respect to benefits payable under the Policy in excess of the amount necessary, We shall have the right to recover such payments. We shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, We shall have the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

Administrative Provisions

Premiums: The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

Changes In Premium Rates: We may change the premium rates from time to time with at least 60 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 consecutive months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place.

- The terms of the Policy change.
- A division, subsidiary, affiliated organization or eligible class is added or deleted from the Policy.
- There is a change in the factors bearing on the risk assumed.
- Any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

Policyholder is hereby notified that beginning in 2014, the Affordable Care Act (ACA) requires that covered entities providing health insurance ("health insurer") pay an annual fee to the federal government (the "Health Insurer Fee"). The amount of this fee for a calendar year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums from the preceding calendar year. In addition, ACA provides for the establishment of temporary transitional reinsurance program(s) that will run from 2014 through 2016 and will be funded by reinsurance contributions ("Reinsurance Fee") from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how the Reinsurance Fee is calculated. Your premium has been adjusted to reflect the effects of the Health Insurer Fees and the Reinsurance Fees.

Payment of Premium: The first Premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period: A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end upon the expiration of the Grace Period. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force.

Reinstatement: If this Policy terminates due to default in premium payment(s), the subsequent acceptance of such defaulted premium by Us or any duly authorized agents shall fully reinstate the Policy. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of the Policy shall not be deemed a waiver of either the requirement of timely premium payment or the right of termination for default in premium payment in the event of any future failure to make timely premium payments.

Currency: All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

ParPlan Provider Arrangement

A Provider who is not a Network Provider will be considered an Out-of-Network Provider. An Out-of-Network Provider may participate in a ParPlan Arrangement, which is a simple direct-payment arrangement in which the Provider agrees to:

- file all claims for the Covered Person;
- accept the Allowable Amount determination as payment for Medically Necessary services, and
- not bill the Covered Person for services over the Allowable Amount determination. Benefits will be subject

to the Out-of-Network:

- Deductible, Copayment(s), Coinsurance;
- limitations and exclusions; and
- maximums.

Notice of Termination of PPO Arrangement with Network Providers

If the Insurer terminates a PPO arrangement with a Network Provider, proper notice will be sent to Insureds advising them of the Insurer's termination and will make available a current listing of Network Providers. The Insurer's termination of a Network Provider, except for reasons of medical incompetence or unprofessional behavior, shall not release the Doctor from the generally recognized obligation to treat the Covered Person and to cooperate in arranging for appropriate referrals. Nor does it release the Insurer from the obligation to reimburse the Covered Person at the Network Provider rate if, at the time of the Insurer's termination of the Network Provider, the Covered person has special circumstances such as a disability, acute condition, or life- threatening illness or is past the 13th week of pregnancy and is receiving treatment in accordance with the dictates of medical practice. ("Special circumstances" means a condition such that the treating Doctor reasonably believes that discontinuing care by the treating Doctor could cause harm to the patient.) Special circumstances will be identified by the treating Doctor, who must request that the Covered Person be permitted to continue treatment under the Doctor's care and agree not to seek payment from the patient of any amounts for which the Covered Person would not be responsible if the Physician were still a Network Provider. The continuity of coverage under this provision will not be extended beyond 90 days of the effective date of the Insurer's termination of the Provider (beyond 9 months in the case of a Covered Person who has been diagnosed with a terminal illness). However, if the Covered Person, at the time of the Network Provider's termination, is past the 13th week of pregnancy, the continuity will be extended through delivery of the child, immediate post-partum care, and the follow-up checkups within the first 6 weeks of delivery.

General Provisions

Entire Contract: The entire contract consists of the Policy (including any endorsements or amendments), the signed application of the Policyholder, the student enrollment form, benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Policy, or to extend the time for payment of premiums, or to waive any of the Insurer's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Insurer's officers and delivered to the Policyholder.

Policy Effective Date: The Policy begins on the Policy Effective Date at 12:00 AM, Standard Time at the address of the Policyholder.

Policy Termination: We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder. Either We or the Policyholder may terminate this Policy on any Premium due date by giving 31day advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and Us.

This Policy terminates automatically on the earlier of:

- the Policy Termination Date shown in the Policy;
- the Premium due date if Premiums are not paid when due; or
- the Policy Effective Date of the renewal of this Policy if a Student decides to renew coverage under this Policy, and the Policy Effective Date of the renewal of this Policy becomes effective before this Policyterminates.

Termination takes effect at 11:59 PM, Standard Time at the address of the Policyholder on the date of termination.

Premium Rebates, and Premium Abatements; and Cost-Sharing:

a. **Rebate.** In the event federal or state law requires Blue Cross and Blue Shield to rebate a portion of annual premiums paid, Blue Cross and Blue Shield will provide any rebate as required or allowed by such federal or state law.
b. **Abatement.** Blue Cross and Blue Shield may from time to time determine to abate (all or some of) the premium due under this Policy for particular period(s). Any abatement of premium by Blue Cross and Blue Shield represents a determination by Blue Cross and Blue Shield not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Policy. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future periods.
c. Blue Cross and Blue Shield makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each person owed or provided a rebate or anabatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.
d. **Cost-sharing.** Blue Cross and Blue Shield reserves the right from time to time to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Policy.

Examination of Records and Audit: We shall be permitted to examine and audit the Policyholder's books and records

at any time during the term of the Policy and within 2 years after final termination of the Policy as they relate to the Premiums or subject matter of this insurance.

Clerical Error: A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

Legal Actions: No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years (5 years in Kansas, 6 years in South Carolina, and the applicable statute of limitations in Florida) after the time written proof of loss is required to be furnished.

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 Policy and there shall be an equitable adjustment of premium rate made so that We will be paid the premium rate at the true age for the Participant.

Conformity with State Statutes: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

Not in Lieu of Workers' Compensation: This Policy is not a Workers' Compensation policy. It does not provide any Worker's Compensation benefit.

Information and Medical Records: All claim information, including, but not limited to, medical records, will be kept confidential and except for reasonable and necessary business use, disclosure of such confidential claim information would not be performed without the authorization of the Covered Person or as otherwise required or permitted by applicable law.

Proprietary Materials: The Policyholder acknowledges that We have developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which are proprietary information ("Business Proprietary Information"). The Policyholder shall not use or disclose to any third party Business Proprietary Information without Our prior written consent. Neither party shall use the name, symbols, trademarks or service marks of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that We may include the Policyholder in its list of clients.

Separate Financial Arrangements Regarding Prescription Drugs:

Separate Financial Arrangements with Network Prescription Drug Providers:

The maximum amount of benefits payable and all required Copayment, Deductible and Coinsurance Amounts under this Contract shall be calculated on the basis of the Provider's billed charge or the agreed upon cost between the Network Prescription Drug Provider as defined below, and Us, whichever is less.

We hereby disclose that We have contracts, either directly or indirectly, with prescription drug providers ("Network Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all Covered Persons.

The Policyholder understands that We may receive such discounts during the term of the contract. Neither the Policyholder nor Covered Person hereunder is entitled to receive any portion of any such discounts in excess of any amount that may be reflected in the Policy.

Separate Financial Arrangements with Pharmacy Benefit Managers:

We hereby inform the Policyholder and all Covered Persons that it owns a significant portion of the equity of Prime Therapeutics LLC and that We have entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all Covered Persons entitled to prescription drug benefits under this Policy.
Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. Pharmacy Benefit Managers may share a portion of those rebates with Us.

The Policyholder understands that We may receive such discounts during the term of the contract. Neither the Policyholder nor Covered Person hereunder is entitled to receive any portion of any such discounts in excess of any amount that may be reflected in the Policy.

Severability: In case any one or more of the provisions contained in this Policy shall, for any reason, beheld to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Policy and the Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

Third Party Data Release: In the event a third party has access to confidential data, third party consultants must acknowledge and agree:
To maintain the confidentiality of the confidential information and any proprietary information (for purposes of this section, collectively, "Information")
The third party consultant and/or vendor shall:

- Use the Information only for necessary business purposes.
- Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the business need.
- Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.
- Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
- Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of the Policy or as required by law.

Not to use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.
The third party consultant and/or vendor shall execute Our then-current confidentiality agreement.
The third party consultant and/or vendor shall be designated on the appropriate HIPAA documentation.

The Policyholder shall indemnify, defend and hold harmless Us and Our employees, officers, directors and agents against any and all losses, liabilities, damages, penalties and expenses, including attorneys' fees and costs, or other cost or obligation resulting from or arising out of claims, lawsuits, demands, settlements or judgments brought against Us in connection with any claim based upon Our disclosure to the third party consultant and/or vendor of any information and/or documentation regarding any Covered Person at the direction of the Policyholder or breach by the third party consultant and/or vendor of any obligation described in the Policy.

Notice of Annual Meeting: The Policyholder is hereby notified that it is a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative

or by proxy at all meetings of Members of said Company. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m. For purposes of the aforementioned paragraph the term "Member" means the group, trust, association or other entity to which this Policy has been issued. It does not include Covered Persons under the Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Policy to "premium(s)" shall mean "charge(s)."

Service Mark Regulation: On behalf of the Policyholder and its Covered Persons, the Policyholder hereby expressly acknowledges its understanding that the Policy constitutes a contract solely between the Policyholder and Us. We are an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits Us to use the Blue Cross and Blue Shield Service Mark in Our service area and We are not contracting as the agent of the Association. The Policyholder further acknowledges and agrees that it has not entered into the Policy based upon representations by any person other than persons authorized by Us and that no person, entity or organization other than the Insurer shall be held accountable or liable to the Policyholder for any of Our obligations to the Policyholder created under the Policy. This paragraph shall not create any additional obligations whatsoever on Our part, other than those created under other provisions of this Policy.

Rescission of Coverage: We may not void coverage based on a misrepresentation by a Covered Person unless the Covered Person performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact with the intent to deceive the Plan on the Covered Person's application; having done so will result in the cancellation of coverage for the Covered Person (and/or the Covered Person's Dependent's or Dependents' coverage) retroactive to the effective date, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, Blue Cross and Blue Shield of Texas may deduct from the premium refund any amounts made in Claim Payments during this period and the Covered Person may be liable for any Claim Payment amount greater than the total amount of premiums paid during the period for which cancellation is affected.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

Texas law establishes a system, administered by the Texas Life and Health Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the Texas Insurance Code, Chapter 463.)

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

Eligibility for Protection by the Association

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

Residents of Texas at the time that their insurance company is impaired. Residents of other states, ONLY if the following conditions are met:

- The policyholder has a policy with a company based in Texas;
- The company has never held a license in the policyholder's state of residence;
- The policyholder's state of residence has a similar guaranty association; and
- The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Health Insurance:

Up to a total of $500,000 for one or more policies for each individual covered.

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

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

Texas Life and Health Insurance Guaranty Association 515 Congress Avenue, Suite 1875 Austin, Texas 78701 800-982-6362 www.txlifega.org	Texas Department of Insurance P.O. Box 149104 Austin, Texas 78714-9104 800-252-3439

EXHIBIT A. PLAN SERVICE AREA LISTING
APPLICABLE ONLY TO MANAGED HEALTH CARE BENEFIT COVERAGE
(In-Network and Out-of-Network Benefits)

STATE	BLUE CROSS AND BLUE SHIELD PLAN	PLAN SERVICE AREA
Alabama	Blue Cross and Blue Shield of Alabama	State-wide
Alaska	Blue Cross of Washington and Alaska (Premera)	State-wide
Arizona	Blue Cross and Blue Shield of Arizona	State-wide
Arkansas	Arkansas Blue Cross and Blue Shield	State-wide
California	Blue Shield of California Blue Cross of California	State-wide
Colorado	Blue Cross and Blue Shield of Colorado	State-wide
Connecticut	Anthem Blue Cross and Blue Shield (Connecticut)	State-wide
Delaware	Blue Cross and Blue Shield of Delaware	State-wide
District of Columbia	Care First Blue Cross and Blue Shield (DC)	State-wide (Maryland only)
Florida	Blue Cross and Blue Shield of Florida (BlueCard PPO Network)	State-wide
Georgia	Blue Cross and Blue Shield of Georgia	State-wide
Hawaii	Blue Cross and Blue Shield of Hawaii	State-wide
Idaho	Blue Cross of Idaho Regence Blue Shield of Idaho	State-wide
Illinois	Blue Cross and Blue Shield of Illinois	State-wide
Indiana	Anthem Blue Cross and Blue Shield (Indiana)	State-wide
Iowa	Wellmark Blue Cross and Blue Shield of Iowa	State-wide
Kansas	Blue Cross and Blue Shield of Kansas	State-wide, excluding Johnson and Wyandotte Counties
Kentucky	Anthem Blue Cross and Blue Shield (Kentucky)	State-wide
Louisiana	Blue Cross and Blue Shield of Louisiana (Preferred Care PPO Network)	State-wide
Maine		State-wide
Maryland	Care First BlueCross and BlueShield (Maryland)	State-wide
Massachusetts	Blue Cross and Blue Shield of Massachusetts	State-wide
Michigan	Blue Cross and Blue Shield of Michigan	State-wide
Minnesota	Blue Cross and Blue Shield of Minnesota	State-wide
Mississippi	Blue Cross and Blue Shield of Mississippi	State-wide
Missouri	Blue Cross and Blue Shield of Kansas City (Preferred Care Network) Alliance Blue Cross and Blue Shield (St. Louis)	State-wide
Montana	Blue Cross and Blue Shield of Montana	State-wide
Nebraska	Blue Cross and Blue Shield of Nebraska	State-wide
Nevada	Blue Cross and Blue Shield of Nevada	State-wide
New Hampshire	Blue Cross and Blue Shield of New Hampshire	State-wide

New Jersey	Horizon Blue Cross and Blue Shield of New Jersey	State-wide
New Mexico	Blue Cross and Blue Shield of New Mexico	State-wide
New York	Empire Blue Cross and Blue Shield Blue Cross and Blue Shield of Western New York Blue Shield of Northeastern New York Blue Cross and Blue Shield of Rochester Area Blue Cross and Blue Shield of Central New York Blue Cross and Blue Shield of Utica-Watertown	State-wide
North Carolina	Blue Cross and Blue Shield of North Carolina (Preferred Care Select Network)	State-wide
North Dakota	Blue Cross and Blue Shield of North Dakota	State-wide
Ohio	Anthem Blue Cross and Blue Shield (Ohio) (Community Preferred Health Plan Network)	State-wide
Oklahoma	Blue Cross and Blue Shield of Oklahoma	Metropolitan areas of Oklahoma City and Tulsa, Lawton, Edmond, Shawnee, Hugo, Tahlequah, Cushing, Potaeu, Pryor and some other communities
Oregon	Regence Blue Cross and Blue Shield of Oregon	State-wide
Pennsylvania	Capital Blue Cross Independence Blue Cross Highmark Blue Cross and Blue Shield (Independence Blue Cross, Capital Blue Cross and Blue Cross of Northeastern Pennsylvania) Highmark Blue Cross and Blue Shield Blue Cross of Northeastern Pennsylvania	State-wide
Rhode Island	Blue Cross and Blue Shield of Rhode Island	State-wide
South Carolina	Blue Cross and Blue Shield of South Carolina	State-wide
South Dakota	Wellmark Blue Cross and Blue Shield of South Dakota	State-wide
Tennessee	Blue Cross and Blue Shield of Tennessee	State-wide
Texas	Blue Cross and Blue Shield of Texas	State-wide
Utah	Regence Blue Cross and Blue Shield of Utah	State-wide
Vermont	Blue Cross and Blue Shield of Vermont	State-wide
Virginia	Anthem Blue Cross and Blue Shield of South East	State-wide, exclusive of Amherst, Appomattox, Campbell, Culpeper counties and the city of Lynchburg
Washington	Premera Blue Cross Regence Blue Shield Northwest Washington Medical Bureau	State-wide
West Virginia	Mountain State Blue Cross and Blue Shield	State-wide

Wisconsin	Blue Cross and Blue Shield United of Wisconsin	State-wide
Wyoming	Blue Cross and Blue Shield of Wyoming	Laramie County Only
Puerto Rico	TRIPLE S and La Cruz Azul de Puerto Rico	Island-wide

Notices