AcademicBlue℠

The University of Houston System Student Sports Insurance Plan 2025-2026

Underwritten by: Blue Cross and Blue Shield of Texas

Please review to understand your coverage.

Account Number: 294685

AcademicBlue is offered by 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

9202234.0225

AcademicBlue℠

POLICYHOLDER:	University of Houston System
POLICY NUMBER:	294685 (“the Policy”)
EFFECTIVE DATE:	August 1, 2025
POLICY TERM:	August 1, 2025 through July 31, 2026
PREMIUM DUE DATE:	On or before the Policy Effective Date

This Policy describes the terms and conditions of coverage as issued to the Policyholder named above. This Policy is issued in the state of Texas and is governed by its laws. This Policy becomes effective at 12:01 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 this 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 participation in a Qualifying Intercollegiate Sport of the Policyholder’s Institution. If Covered Persons have any questions once they have read this Policy, they can call Us at the toll-free telephone number on the back of their identification card. It is important to all of Us that Covered Persons understand the protection this coverage gives them.

10 DAY RIGHT TO RETURN THIS POLICY - If for any reason the Covered Person is not satisfied with this Policy, they may return it to us within 10 days after receiving it. Upon its return, we will return any premium paid and this Policy will be deemed void, as though it had never been issued.

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

James Springfield
Plan President, Blue Cross and Blue Shield of Texas

BLANKET STUDENT SPORT ACCIDENT INSURANCE

PLEASE READ THIS POLICY CAREFULLY.
IT PAYS BENEFITS FOR SPECIFIC LOSSES FROM ACCIDENT ONLY.
BENEFITS ARE NOT PAID FOR LOSS DUE TO SICKNESS.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare.

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.

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

Notice

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.

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

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 this 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 this 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 WHEN OUT-OF-NETWORK PROVIDERS ARE USED. Network Providers have agreed to accept discounted payments for services with no additional billing to the Covered Person other than applicable Copayments, Coinsurance and Deductible amounts. However, if you (1) pay the Provider a rate less than the average discounted rate that would be paid by BCBSTX to a Network Provider directly for a covered and Medically Necessary service or supply; and (2) the Provider does not submit a claim to BCBSTX for that service or supply; you may submit the appropriate documentation with a Claim Form to BCBSTX and allowable credit will, as applicable, be applied towards your Network Deductible and Out-of-Pocket Maximums.

Except in the circumstances described below, Out-of-Network Providers may bill a Covered Person for any amount up to the billed charge after the plan has paid its portion of the bill. However, if you (1) pay the Provider a rate less than the average discounted rate that would be paid by BCBSTX to a Network Provider directly for a covered and Medically Necessary service or supply; and (2) the Provider does not submit a claim to BCBSTX for that service or supply; you may submit the appropriate documentation with a Claim Form to BCBSTX and allowable credit will, as applicable, be applied towards your Network Deductible and Out-of-Pocket Maximums.

If services are obtained at a participating Hospital, at a participating Surgery center or other participating treatment center, and services are provided by an Out-of-Network anesthesiologist (including a certified registered nurse anesthetist), pathologist, radiologist, neonatologist, or emergency room Physician, assistant surgeon (if the primary surgeon is a Network Provider) or other Hospital-based Physician, the Covered Person will incur no greater out-of-pocket costs than would have been incurred if the services were provided by a Network Provider. For services provided by a Texas-licensed non-participating Provider, unless Covered Person has signed a written notice and disclosure, in the form and following the requirements adopted by the Texas Department of Insurance, allowing the Out-of-Network Provider to bill Covered Person for amounts above the non-contracting Allowed Amount, the nonparticipating Provider may not bill the Covered Person for the difference between payment by this Plan and the Provider charges plus Network Deductible, Coinsurance and/or Copayment. For services provided by an Out-of-Network Provider not licensed in Texas, the Out-of-Network Provider may bill the Covered Person for the difference between payment by the Plan and the Provider charges plus Network Deductible, Coinsurance and/or Copayment. Please call Customer Service if you have been balance billed by the Out-of-Network Provider, or if you have any questions about the Benefits described in this section (paragraph) or how your Claims have been processed.

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 back of their identification card.

For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Texas Customer Service at the toll-free telephone number on the back of your identification card. 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.

Have a complaint or need help?

If you have a problem with a Claim or your premium, call your insurance company or HMO. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
To get information or file a complaint with your insurance company or HMO:
Call: Blue Cross and Blue Shield of Texas
Toll-Free: 1-888-654-9390
Email: BCBSTXComplaints@bcbstx.com
Mail: P. O. Box 660044, Dallas, TX 75266-0044

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:
Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov Email: ConsumerProtection@tdi.texas.gov
Mail: Consumer Protection, MC: CO-CP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation
Para obtener información o para presentar una queja ante su compañía de seguros o HMO:
Llame a: Blue Cross and Blue Shield of Texas
Teléfono gratuito: 1-888-654-9390
Correo electrónico: BCBSTXComplaints@bcbstx.com Dirección postal: P. O. Box 660044, Dallas, TX 75266-0044

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame con sus preguntas al: 1-800-252-3439 Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: Consumer Protection, MC: CO-OP, Texas Department of Insurance, PO Box 12030, Austin, TX 78711-2030

Important Notice-Student-5-2020

YOUR RIGHTS WITH A PREFERRED PROVIDER BENEFIT PLAN (PPO)

Notice from the Texas Department of Insurance

Your plan

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. You can go to any doctor or facility you choose, but your costs will be lower if you use one in the plan's network.

Your plan's network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

Health care costs

You can ask health care providers how much they charge for health care services and procedures. You can also ask your health plan how much of the cost they'll pay.

List of doctors

You can get a directory of health care providers that are in your plan's network. You can get the directory online at www.bcbstx.com or by calling 1-800-521-2227. If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Health care bills

If you want to see a doctor or facility that isn't in your plan's network, you can still do so. You'll probably get a bill and have to pay the amount your health plan doesn't pay.

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

Table of Contents

Schedule of Benefits

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

For questions concerning Out-of-Network Providers, please call Blue Cross and Blue Shield of Texas Customer Service at the toll-free telephone number on the back of your identification card.

ACCIDENT MEDICAL EXPENSE BENEFITS

Unless otherwise specified, Coinsurance percentages, Deductibles, and Benefit Maximums apply on a per Covered Person, per Benefit Period per Covered Accident basis.

SCOPE OF COVERAGE:

The overed Injury must result directly, and independently of all other causes, from a Covered Accident.

Benefits will be paid at the applicable Benefit rate up to the Benefit Maximum.

Benefit Maximum	$50,000

Deductible per Coverage Period	$350	$700

Benefit Period:	52 weeks from the date of the Covered Accident
Student must be covered under this Policy at the time of the Covered Accident.	

Incurral Period:

First Covered Expense must be incurred within 365 days from the date of a Covered Accident.

	Network Provider Covered Person Pays	**Out-of-Network Provider Covered Person Pays**
Covered Accidents	20% of Allowable Amount	40% of Allowable Amount

Definitions

Throughout this Policy, many words are used which have a specific meaning when applied to a Covered Person's Accident 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 covered under this 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 the toll-free telephone number on the back of their identification card.

Notwithstanding the above, where applicable state or federal law requires another standard for a non-contracting

claim, the Allowable Amount shall be the lessor of billed charge or the amount prescribed by law.

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 non-Emergency Care provided by an Out-of-Network Provider when a contracting Provider is not reasonably available as defined by applicable law or when services are pre-approved or Prior Authorized based upon the unavailability of a Preferred Provider and balance billing is not prohibited by Texas or Federal law – The Allowable Amount will be the Plan usual and customary charge as defined by Texas law or as prescribed under applicable law and regulations, or at a rate agreed to between BCBSTX and the Out-of-Network Provider, not to exceed billed charges.

For Out-of-Network Emergency Care, care provided by an Out-of-Network facility-based Provider in a Network Hospital, ambulatory surgery center or birthing center, or services provided by an Out-of-Network Laboratory or Diagnostic Imaging Service in connection with care delivered by a Network Provider – the Allowable Amount will be the Plan usual and customary rate or at a rate agreed to between BCBSTX and the Out-of-Network Provider as prescribed by the Texas Insurance Code, not to exceed billed charges. The Plan's usual and customary rate will be based upon our rate information for the same or similar services. The usual and customary rate shall not be less that the non-contracting Allowable Amount as defined in this Plan.

Benefit means the payment, reimbursement, and indemnification of any kind which Covered Persons will receive from, and through the Plan, under this Policy.

Benefit Maximum means the total amount of Covered Expenses payable under this Policy per Covered Person per Coverage Period.

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 BCBSTX.

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.

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").

Coverage Period means the period of time starting with the date the Covered Accident occurs through the end of the Coverage Period as shown on the Face page of the Policy. The Coverage Period is as agreed to by the Policyholder and the Insurer.

Covered Accident means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury arising from a Qualifying Intercollegiate Sport as defined and covered by this Policy for which Benefits are payable, and which:

1. Occurs while he or she is participating in a Covered Event;
2. Occurs during Covered Travel to or from the location of a Covered Event;
3. Occurs during a temporary stay at the location of a Covered Event held away from the location of the Institution while the Covered Person is engaged in an activity or travel that is authorized by, organized by, or directly supervised by an official representative of the Institution; or
4. Results from a cardiovascular Accident or stroke or other similar traumatic event caused by exertion while participating in a Covered Event.

Covered Event means an event as described in the Covered Events section of this Policy in which a Covered Person must be engaged when a Covered Accident occurs in order for Covered Expenses to be payable under this Policy.

Covered Expense means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by this Policy. Coverage under this Policy must remain continuously in force from the date the Accident 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 Person means any eligible Student who applies for coverage, and for whom the required premium is paid.

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

Covered Travel means team or individual travel, for purposes of representing the Institution, that is to or from the location of a Covered Event and is authorized by the Institution, provided the travel is paid for or subject to reimbursement by the Institution. Covered Travel to a Covered Event will commence upon embarkation from an authorized departure point and terminate upon arrival at the location of the Covered Event.

Covered Travel from a Covered Event will commence upon departing from the location of the Covered Event and terminate upon return to the authorized place from which such Covered Travel to the Covered Event began.

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 this Policy.

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.

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 or Injury is of such a nature that failure to get immediate care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or

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

Services provided in an emergency room that are not Emergency Care may be excluded from emergency coverage, although these services may be covered under another Benefit, if applicable.

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:

1. Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated;
2. Are appropriate for the Hospital or facility other Provider in which they were performed; and
3. The Physician or professional other Provider has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of 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.

Hospital means a short-term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
2. Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or behavioral health practitioners for compensation from its patients;
3. 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;
4. Provides 24-hour nursing services by or under the supervision of a registered nurse; and
5. Has in effect a Hospital Utilization Review Plan.

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.

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

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:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the Injury;
2. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States;
3. Not primarily for the convenience of the Covered Person, their Physician, behavioral health practitioner, the Hospital, or the other Provider;
4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Covered Person. When applied to hospitalization, this further means that the Covered Person requires acute care as a bed patient due to the nature of the services provided or the Covered Person's condition, and the Covered Person cannot receive safe or adequate care as an outpatient; and
5. If more than one health intervention meets the requirements listed above, Medically Necessary means "the most cost effective in terms of type of intervention or setting, frequency, extent, or duration, which is safe and effective for the patient's illness, Injury, or disease and supports improved health."

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.

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.

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.

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.

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.

Physician means a person, when acting within the scope of their 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.

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

Provider means a Hospital, Doctor, other Provider, or any other person, company, or institution furnishing to a Covered Person an item of service or supply listed as Covered Expenses.

Qualifying Intercollegiate Sport means a sport:

1. Which is not an Interscholastic Activity (as defined in this Policy);
2. Which is administered by such Institution's department of intercollegiate athletics; and
3. For which Benefits for Covered Accidents are provided for and payable under this Policy while Covered Persons are playing, participating, and/or traveling to or from an Intercollegiate Sport, contest or competition, including practice or conditioning for such activity.

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

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.

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

Eligibility for Insurance

Each person in one of the Classes of Eligible Persons shown below is eligible to be covered under this Policy. Please contact your Institution for further information. Students must maintain their eligibility in order to maintain or continue coverage under this policy. We maintain the right to investigate Student status and attendance records to verify that eligibility requirements have been met.

CLASSES OF ELIGIBLE PERSONS:

Class 1: All Student athletes are eligible for coverage under this Policy.

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, quality of life, 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, expected length of life, sex, gender identity, sexual orientation, or political affiliation. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving Benefits. 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, disincentives and/or other programs do not constitute discrimination.

Effective Date and Termination of Coverage

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

1. The Policy Effective Date;
2. The date the required premium is paid;
3. The date the Student enters the Eligible Class.

TERMINATION DATE OF INSURANCE

A Student's coverage will end on the earliest of the date:

1. The Policy terminates;
2. The Student is no longer in the eligible class;
3. The period ends for which premium is paid.

REFUND OF PREMIUM

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

1. Of a Covered Person's death; or
2. The Covered Person enters full-time active duty in any Armed Forces and We receive proof of such active-duty service.

Covered Events

FOR PLAYERS ON AN ATHLETIC TEAM

1. A Qualifying Intercollegiate Sport competition scheduled by the Institution;
2. Official team activities;
3. Conditioning*; and
4. Practice sessions.

For players on an athletic team, a Covered Event must be authorized by, organized by or directly supervised by an official representative of the Institution (not including any activities not directly a part of a Qualifying Intercollegiate Sport, such as camps, clinics and other events not conducted by the Institution).

For Student coaches, Student managers and Student trainers, only those activities directly associated with the covered activities of a Qualifying Intercollegiate Sport team or covered activities of Student cheerleaders and under the direct supervision of an official representative of the Institution.

FOR STUDENT CHEERLEADERS

1. Activities performed as part of the cheer unit for a Qualifying Intercollegiate Sport team competition scheduled by the Institution; and
2. Practice sessions and pep rallies both of which must be authorized by, organized by, and directly supervised by a safety-certified official coach or advisor of the Institution, other than a member of the cheer unit or other undergraduate Student, and in preparation for a Qualifying Intercollegiate Sport team competition.

The coach or advisor must have a current safety certification by a nationally recognized formal credentialing program for safety certification. However, the safety-certification requirement does not apply with respect to practice sessions that are held solely by dance team members or mascots. A graduate Student can meet the safety-certification requirement if:

1. Officially designated by the Institution as the official coach or advisor; and
2. The Institution has given the graduate Student the authority to authorize, organize and directly supervise.

Covered Event, for Student cheerleaders, does not include any activities, camps, clinics, national competitions, fund-raisers, alumni events; unless the activity is directly associated with the activities of a Qualifying Intercollegiate Sport team or conducted by the Institution.

*To be covered, conditioning must meet the following three criteria:

1. It must be authorized by, organized by, or directly supervised by an official representative of the Institution;
2. It must contribute directly toward the Student-athlete's ability to participate as a player in their particular sport; and
3. It must take place at the Institution's athletic facilities, or a facility authorized by the Institution.

Accident Medical Expense Benefits

We will pay the Covered Expenses as shown in the Schedule of Benefits that result directly, and from no other cause, from a Covered Accident. We will consider the Allowable Amount incurred for Medically Necessary Covered Expenses. Benefit payments are subject to the Coinsurance and Benefit Maximum factors shown in the Schedule of Benefits as well as any other terms, conditions, limitations, or exclusions described in this Policy. Accident Medical Expense Benefits are only payable under this Policy for those Medically Necessary Covered Expenses that the Covered Person receives within the Coverage Period related to an Injury occurring during a Covered Event.

Initial Covered Expenses must incur within the incurral period as shown on the Face Page of the Policy.

COVERED EXPENSES INCLUDE

Inpatient Expenses

Hospital Expenses:

1. Daily room and board at semi-private room rate when Hospital Confined;
2. General nursing care provided and charged for by the Hospital;
3. Intensive care. We will make this payment in lieu of the semi-private room expenses;
4. Coordinated home care Benefits following Hospital Confinement;
5. 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.
    a. Surgical Expenses: Surgeon's fees for Inpatient Surgery.
    b. Preadmission Testing: when Medically Necessary, in connection with Inpatient Surgery.
    c. Assistant Surgeon Services: When Medically Necessary, in connection with Inpatient Surgery.
    d. Anesthetist Services: in connection with Inpatient Surgery.
    e. Doctor's Visits: when Hospital Confined. Benefits do not apply when related to Surgery.
    f. 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

1. Day Surgery/Outpatient Surgical Expense: Surgeon's fees for Outpatient Surgery.
2. 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.
3. Preadmission Testing: when Medically Necessary, in connection with Outpatient Surgery.
4. Assistant Surgeon Services: when Medically Necessary, in connection with Outpatient Surgery.
5. Anesthetist Services: in connection with Outpatient Surgery.
6. Doctor's Visits.
7. Physical Medicine Services: includes, but is not limited to physical, occupational, and manipulative

therapy.

8. 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.
9. Medical Emergency Expenses: only in connection with Emergency Care as defined.
10. Urgent Care.

Other Expenses

1. Durable Medical Equipment, Prosthetic Appliances, Orthotic Devices, Braces, and Medically Necessary services related to the fitting and use of these devices when prescribed by a Doctor and a written prescription accompanies the Claim when submitted. Replacement or repairs to braces and appliances are covered unless the repair or replacement is necessitated by misuse or loss by the Covered Person. Durable medical equipment is equipment that:
    a. Is primarily and customarily used to serve a medical purpose;
    b. Can withstand repeated use; and
    c. Generally, is not useful to person in the absence of Injury.

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

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

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

    No Benefits will be paid for rental charges in excess of the purchase price.
2. Ambulance Service.
3. Consultant Doctor Fees: when requested and approved by the attending Doctor.
4. 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.
5. Skilled Nursing Facility.
6. Coordinated Home Health Care.
7. Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Covered Person.
8. Oxygen and its administration provided the oxygen is actually used.
9. Benefits for Prescription Drugs will only be covered for Medically Necessary Prescription Drugs for the treatment of a Covered Accident.

Acquired Brain Injury

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

1. Cognitive Rehabilitation therapy;
2. Cognitive communication therapy;
3. Neurocognitive therapy and Rehabilitation;
4. Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment;
5. Neurofeedback therapy; and
6. 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:

1. Has been unresponsive to treatment; and
2. Becomes responsive at a later date.

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

1. Cost;
2. The time elapsed since the prior evaluation;
3. Differences in the expertise of the Provider performing the evaluation; and
4. Changes in technology and advances in medicine.

Benefits for acquired brain Injury will not be subject to any visit limit indicated on your Schedule of Benefits. 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's 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 this Policy.

Exclusions and Limitations

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

1. Charges that are not Medically Necessary or in excess of the Allowable Amount;
2. Services that are provided, normally without charge, by the Student Health Center, infirmary, or Hospital, or by any person employed by the University;
3. Sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof;
4. Any charges for Surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are Experimental or Investigational;
5. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which Benefits are otherwise payable under this Policy.
6. Any Injury suffered by a Covered Person arising from travel that is neither authorized by the Institution nor paid for or subject to reimbursement by the Institution;
7. Any Injury suffered by a Covered Person where the Institution required the Covered Person to sign a waiver relieving that Institution of responsibility or liability based on notification by a Doctor that the Covered Person's participation exposed the Covered Person to increased risk for that type of Injury, cardiovascular accident or stroke or other similar traumatic event incurred;
8. Bio-feedback procedures;
9. 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 the repair of Injuries to sound natural teeth caused by a covered Injury;
10. Acupuncture procedures;
11. Custodial Care;
12. Long term care service;
13. Private duty nursing services;
14. Intentional self-inflicted Injury, except when the Injury results from a medical condition or an act of domestic violence;
15. Expenses incurred for Injury arising out of or in the course of a Covered Person's employment regardless of if Benefits are, or could be paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
16. 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;

COORDINATION OF BENEFITS

We will pay the Covered Expenses a Covered Person incurs for Covered Services that exceed amounts payable by any other insurance plan, subject to the Coinsurance, Deductible, Benefit Maximums, and Benefit Period shown in the Schedule of Benefits. We will determine the amount of benefits provided by any other insurance plan without reference to any coordination of Benefits, non-duplication of Benefits or similar provisions. The amount of benefits provided by another insurance plan includes any amount to which the Covered Person is entitled whether or not a Claim is made for the benefits. This Policy is secondary to all other insurance plans.

The first Covered Expense must be incurred within the incurral period stated in the Schedule of Benefits.

The Benefit Maximum payable and other limits under this Policy are shown in the Schedule of Benefits.

NON-DUPLICATION OF BENEFITS LIMITATION

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

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.

Proof 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:

1. It was not reasonably possible to provide proof in that time; and
2. 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.

Accident Report: Written Accident Report must be furnished to the Insurer and will be reviewed against any proof of loss in order for Benefits to be payable under the Policy.

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:

1. Pay the Benefits due; or
2. 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 workdays in which to:

1. Process and either pay the Claim, in whole or in part, or deny it; and
2. 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-workday 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 this Policy.

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

1. 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 Health and Human Services Commission, 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.

2. 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.
3. 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.

Assignment: At the request of the Covered Person or their 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 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, 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.

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 Prior Authorization, 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 Schedule of Benefits 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:

1. The reasons for determination;
2. The professional specialty of the Physician who made the determination;
3. A reference to the Benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination; and
4. 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:

1. An explanation of our internal review/appeals processes and how to initiate a review/appeal;
2. 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);
3. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;
4. 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;
5. 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;
6. 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;
7. 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;
8. 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;
9. 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
10. 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 Covered Person 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 have received Prior Authorization 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 Prior Authorization 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 Prior Authorization, 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 their 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 toll-free telephone number on the back of your identification 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:

1. 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

2. BCBSTX will honor telephone requests for information. However, such inquiries will not constitute a request for review.
3. 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 Claim procedures or the review procedure, write to our Administrative Office or call Customer Service at the toll-free telephone 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 Prior Authorization 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:

1. A reason for the determination;
2. The professional specialty of the Physician who made the determination;
3. A reference to the Benefit plan provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
4. 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;
5. 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;
6. 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);
7. In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by BCBSTX;
8. 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;
9. 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;
10. 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;
11. A description of the standard that was used in denying the Claim and a discussion of the decision;
12. Your right, if applicable, to request external review by and Independent Review Organization; and
13. 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 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.

1. BCBSTX will submit medical records, names of Providers and any documentation pertinent to the decision of the IRO.
2. BCBSTX will comply with the decision by the IRO.
3. 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:

1. Information relied upon to make the decision;
2. Information submitted, considered, or generated in the course of making the decision, whether or not it was relied upon to make the decision;
3. Descriptions of the administrative process and safeguards used to make the decision;
4. Records of any independent reviews conducted by BCBSTX;
5. Medical judgments, including whether a particular service is Experimental/Investigational or not Medically Necessary or appropriate; and
6. 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.

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:

1. The terms of the Policy change;
2. A division, subsidiary, affiliated organization, or eligible class is added or deleted from the Policy;
3. There is a change in the factors bearing on the risk assumed; or
4. 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.

Payment of Premium: The first Premium is due on the Policy Effective Date.

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:

1. File all Claims for the Covered Person;
2. Accept the Allowable Amount determination as payment for Medically Necessary services; and
3. Not bill the Covered Person for services over the Allowable Amount determination.

Benefits will be subject to the Out-of-Network:

1. Deductible, Copayment(s), Coinsurance;
2. Limitations and exclusions; and
3. 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 Covered Persons 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 Provider from the generally recognized obligation to treat the continuing-care patient 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 is a continuing-care patient. The continuity of coverage under this provision will not be extended beyond the earlier of 90 days or the date on which the Covered Person is no longer a continuing-care patient with respect to such Provider.

A continuing-care patient means a Covered Person who:

1. Is undergoing a course of treatment for a serious and complex condition from the Provider;
2. Is undergoing a course of institutional or inpatient care from the Provider;
3. Is scheduled to undergo non-elective Surgery from the Provider, including receipt of postoperative care from such Provider with respect to such a Surgery;
4. Is pregnant and undergoing a course of treatment for the pregnancy from the Provider; or
5. Is or was determined to be terminally ill and is receiving treatment for such illness from such Provider.

A serious and complex condition is (i) in the case of an acute sickness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or (ii) in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized Medical Care over a prolonged period of time.

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 12:01 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 31 day 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:

1. The Policy Termination Date shown in the Policy;
2. The Premium Due Date if Premiums are not paid when due; or
3. 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 Policy terminates.

Termination takes effect at 12:00 AM, Standard Time at the address of the Policyholder on the date of termination.

Premium Rebates, Premium Abatements, and Cost-Sharing:

1. **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.
2. **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.
3. 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 an abatement to determine the applicability of and comply with any applicable federal, state, or local laws or regulations.
4. **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 after the time written proof of loss is required to be furnished.

Misstatement of Age: In the event the age of a Covered Person 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 Covered Person.

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.

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:

1. Use the Information only for necessary business purposes;
2. 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;
3. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein;
4. 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;

5. 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;
6. Not 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; and

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.

Incontestability: Except as to issues concerning nonpayment of premiums due:

1. The validity of this Policy may not be contested after the Policy has been in force for two years after its date of issue; and
2. In the absence of fraud, no statement made by any Covered Person relating to the individual's insurability may be used in contesting the validity of the coverage with respect to which the statement was made:
    a. After the coverage has been in force for two years; and
    b. Unless the statement is contained in written instrument signed by the individual making the statement.

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 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 $200,000 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, Poteau, 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

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Policies Compliance Disclosure Requirements

Out-of-Area Services

Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation, herein called BCBSTX has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you access healthcare services outside of BCBSTX service area, the Claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the BlueCard Program, and may include Negotiated Arrangements available between BCBSTX and other Blue Cross and Blue Shield Licensees.

When you receive care outside our service area, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("non-participating healthcare Providers") don't contract with the Host Blue. We explain how we pay both types of Providers below.

A. BlueCard® Program

Under the BlueCard Program, when you receive covered healthcare services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever you receive covered healthcare services outside BCBSTX's service area and the Claim is processed through the BlueCard Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to Us.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your Claim because they will not be applied after a Claim has already been paid.

B. Negotiated (non-BlueCard Program) Arrangements

As an alternative to the BlueCard Program, your Claims for covered healthcare services may be processed through a Negotiated Arrangement with a Host Blue.

The amount you pay for covered healthcare services under this arrangement will be calculated based on the lower of either billed covered charges or negotiated price (Refer to the description of negotiated price under Section A., BlueCard Program) made available to us by the Host Blue.

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1. In General

When Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Certificate for Non-Participating Providers located inside our service area. You may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as

set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion negotiate a payment with such Non-Participating Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

a. The amount calculated using the methodology described in the Certificate for Non-Participating Providers located inside your service area (and described in Section C (1.) above); or

b. The following:

   (i) For Professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Certificate for Non-Participating Providers located inside your service area; or an amount based on publicly available provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable, or

   (ii) For Hospital or facility Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Certificate for Non-Participating Providers located inside your service area; or an amount based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the difference between the amount that the Non-Participating Provider bills and the payment Blue Cross and Blue Shield of Texas will make for the Covered Services as set forth in this paragraph.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax, or other fee as part of the Claim Charge passed on to you.

E. Special Cases: Value-Based Programs

BlueCard® Program

If you receive covered healthcare services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to us through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non–BlueCard Program) Arrangements

If BCBSTX has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, we will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

F. Blue Cross Blue Shield Global Core

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing covered healthcare services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the Claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a Doctor or Hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Emergency Care Services**

This Contract covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency Care and Urgent Care obtained outside of the United States. Follow-up care following an emergency is also available, provided the services have received prior authorization by BCBSTX. Any other services will not be eligible for Benefits unless authorized by BCBSTX.

- **Inpatient Services**

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit your Claims to the service center to begin Claims processing. However, if you paid in full at the time of service, you must submit a Claim to receive reimbursement for covered healthcare services.

- **Outpatient Services**

Outpatient Services are available for the treatment of Emergency Care and Urgent Care.

Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a Claim to obtain reimbursement for covered healthcare services.

- **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for covered healthcare services outside the BlueCard service area, you must submit a Claim to obtain reimbursement. For institutional and professional Claims, you should complete a Blue Cross Blue Shield Global Core International Claim form and send the Claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate Claims processing. Following the instructions on the Claim form will help ensure timely processing of your Claim. The Claim form is available from BCBSTX, the BlueCard Worldwide Service Center or online at www.bcbsglobalcore.com If you need assistance with your Claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.