POLICYHOLDER: The University of Texas System

POLICY NUMBER: 212653 ("the Policy")

EFFECTIVE DATE: August 1, 2018

POLICY TERM: August 1, 2018 through July 31, 2019

COVERAGE PERIOD: 52 weeks from the date of a Covered Accident

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. The Policy is issued in the state of Texas and is governed by its laws. The Policy becomes effective at 12:00 A.M. on the Policy Effective Date at the Policyholder's address.

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

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

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

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

BLANKET STUDENT INTERCOLLEGIATE 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.

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.

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.

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

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

IMPORTANT NOTICE

To obtain information or make a complaint:

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

1-800-654-9390

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

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

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

1-800-252-3439

You may write the Texas Department of Insurance:

The Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

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

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

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

1-800-654-9390

Usted tambien puede escribir aBlue Cross and Blue Shield of Texas:

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

Puede comunicarse con el Departamento de Segueros de Texas para obtener informacion acerca de companies, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

El Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771
Web: http://www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del document adjunto.

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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 1-855-267-0214.

CLASSES OF ELIGIBLE PERSONS:

Class I: Health Institution Students- It is a requirement that all Health Science Center and medical students are automatically enrolled in the Student Health Insurance Plan at registration unless proof of comparable coverage is furnished.

Class II: International Students- All international students holding non-immigrant visas are eligible and are required to purchase this Student Health Insurance Plan in order to complete registration, except for those students who certify in writing that comparable coverage is in effect under another plan as approved by The University of Texas (UT) System Board of Regents.

The Board of Regents has authorized the assessment of a health insurance fee to each such international student who cannot provide evidence of continuing coverage under another approved plan. This fee will be the amount of the premium approved for the UT System Student Health Insurance Plan. Required Student Health Insurance coverage for international students includes repatriation and Medical Evacuation benefits.

Class III: All Other Students- All other fee paying students at an institution of the UT System who are taking credit hours, graduate students working on research/dissertation or thesis, post doctorate students, scholars, fellows and visiting scholars are eligible to enroll in this Student Health Insurance Plan.

NOTE: Multiple classes may be added depending on the Institution

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

Students must meet the Institution's requirements for maintaining their status as an eligible Student.

ACCIDENT MEDICAL EXPENSE BENEFITS

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

Scope of Coverage:

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

Benefit Maximum Per Covered Person Per Covered Accident $90,000

Covered Expenses	**Network Provider Policy Pays**	**Out-of-Network Provider Policy Pays**
Covered Accidents	100% of Allowable Amount	100% 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 insured under the Policy.

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

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

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

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

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

We will utilize the same claim processing rules and/or edits that it utilizes in processing Network Provider claims for processing claims submitted by non-contracting 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-contracting Provider will be responsible for the difference between the non-contracting Allowable Amount and the non-contracting Provider's billed charge, and this difference may be considerable. To find out the BCBSTX non-contracting Allowable Amount for a particular service, Covered Persons may call customer service at 1-855-267-0214.

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.

"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 the Insurer.

"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: a) occurs while he or she is participating in a Covered Event; or b) occurs during Covered Travel to or from the location of a Covered Event; or c) 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 d) 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 Expenses" means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date the Covered 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 to Us.

"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.).

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

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

"Experimental or Investigational" means the use of any treatment, procedure, facility, equipment, drug, device, or supply not accepted as *standard medical treatment* of the condition being treated or any of such items requiring Federal or other governmental agency approval not granted at the time services were provided.

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

As used herein, *medical treatment* includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

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

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

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

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

- Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;
- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians or behavioral health practitioners for compensation from its patients;

- Has organized departments of medicine and major surgery, either on its premises or in facilities available to the Hospital on a contractual prearranged basis, and maintains clinical records on all patients;
- Provides 24-hour nursing services by or under the supervision of a registered nurse;
- Has in effect a Hospital Utilization Review Plan; and

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

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

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

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

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

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

"Insured" means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person.

"**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.

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

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, Injury, or bodily malfunction; and
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and
- Not primarily for the convenience of the Covered Person, his or her Physician, behavioral health practitioner, the Hospital, or the other Provider; and
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the 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.

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 his license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the Texas Insurance Code.

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

"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.

"Usual and Customary Fee" means the fee as reasonably determined by Blue Cross and Blue Shield, which is based on the fee which the Physician who renders the particular services usually charges his patients for the same service and the fee which is within the range of usual fees other Physicians of similar training and experience in a similar geographic area charge their patients for the same service, under similar or comparable circumstances. However, if Blue Cross and Blue Shield reasonably determines that the Usual and Customary Fee for a particular service is unreasonable because of extenuating or unusual circumstances, the Usual and Customary Fee for such service shall mean the reasonable fee as reasonably determined by Blue Cross and Blue Shield but in no event shall the reasonable fee be less than the Usual and Customary Fee.

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

ELIGIBILITY FOR INSURANCE

Each person in one of the Class(es) of Eligible Persons shown below is eligible to be insured under this Policy. This includes anyone who is eligible on the Policy Effective Date, and may become eligible after the Policy Effective Date while the Policy is in force. Students must meet the Institution's requirements for maintaining their status as an eligible Student. We maintain the right to investigate student status and attendance records to verify that eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any premium paid for that person.

A person may be insured under only one class of Eligible Persons shown in the Schedule of Benefits, even though the person may be eligible under more than one Class.

EFFECTIVE DATE OF INSURANCE

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:

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

OPEN ENROLLMENT PERIODS

The Plan Administrator along with the Institution will designate open enrollment periods during which Students may apply for or change coverage for himself/herself.

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

DISCONTINUANCE OF INSURANCE

TERMINATION DATE OF INSURANCE

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

- the Policy terminates;
- the Insured is no longer eligible;
- the period ends for which premium is paid; or
- the Policy Effective Date of the renewal of this Policy if a Student decides to renew coverage under this Policy, and the Policy Effective Date of the renewal of this Policy becomes effective before this Policy terminates.

REFUND OF PREMIUM

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

- of a Covered Person's death; or
- 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:

- a Qualifying Intercollegiate Sport competition scheduled by the Institution;
- official team activities;
- conditioning*; or
- 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:

- activities performed as part of the cheer unit for a Qualifying Intercollegiate Sport team competition scheduled by the Institution;
- 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:

- officially designated by the Institution as the official coach or advisor; and
- 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 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 his or her particular sport. 3) And, finally, it must take place at the Institution’s athletic facilities or a facility authorized by the Institution.

BENEFIT DESCRIPTION

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.*

*We will consider the Usual and Customary Fee incurred for Medically Necessary Covered Expenses received for an Out-of-Network Provider.

Covered Expenses include:

Inpatient Expenses

- Hospital Expenses:
  - Daily room and board at semi-private room rate when Hospital Confined;
  - General nursing care provided and charged for by the Hospital;
  - Intensive care. We will make this payment in lieu of the semi-private room expenses;
  - Coordinated home care benefits following Hospital Confinement;
  - Hospital Miscellaneous Expenses: expenses incurred while Hospital Confined or as a precondition for being Hospital Confined, for services and supplies such as the cost of operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, physical therapy, therapeutic services and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.
- Surgical Expense: Surgeon's fees for Inpatient Surgery.
- Preadmission Testing: when Medically Necessary, in connection with Inpatient Surgery.
- Assistant Surgeon Services: When Medically Necessary, in connection with Inpatient Surgery.
- Anesthetist Services: in connection with Inpatient Surgery.
- Doctor's Visits: when Hospital Confined. Benefits do not apply when related to Surgery.
- Staff nursing care while confined to a Hospital by a licensed registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN).

Outpatient Expenses

- Day Surgery/Outpatient Surgical Expense: Surgeon's fees for Outpatient Surgery.
- Day Surgery Miscellaneous Expenses: Services related to scheduled Surgery performed in a Hospital or ambulatory surgical center, including operating room expenses, laboratory tests and diagnostic test expense, examinations, including professional fees, anesthesia; drugs or medicines; therapeutic services and supplies. Benefits will not be paid for: Surgery performed in a Hospital emergency room, Doctor's office, or clinic.
- Preadmission Testing: when Medically Necessary, in connection with Outpatient Surgery.
- Assistant Surgeon Services: when Medically Necessary, in connection with Outpatient Surgery.
- Anesthetist Services: in connection with Outpatient Surgery.
- Doctor's Visits.
- Physical Medicine Services: includes, but is not limited to physical, occupational, and manipulative therapy.
- Diagnostic X-ray and Laboratory Services: when Medically Necessary and performed by a Doctor will include diagnostic services and medical procedures performed by a Doctor, other than Doctor's visits, X-ray and lab procedures.
- Medical Emergency Expenses: only in connection with Emergency Care as defined.
- Urgent Care.

Other Expenses

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

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

- Ambulance Service.
- Consultant Doctor Fees: when requested and approved by the attending Doctor.
- 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.
- Skilled Nursing Facility.
- Coordinated Home Health Care.
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Covered Person.
- Oxygen and its administration provided the oxygen is actually used.
- Benefits for Prescription Drugs will only be covered for Medically Necessary Prescription Drugs for the treatment of a Covered Accident.

EXCLUSIONS AND LIMITATIONS

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

- charges that are not Medically Necessary or in excess of the Allowable Amount;
- services that are provided, normally without charge, by the Student Health Center, infirmary or Hospital, or by any person employed by the University;
- sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof;
- any charges for Surgery, procedures, treatment, facilities, supplies, devices, or drugs that the Insurer determines are Experimental or Investigational;
- cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Policy.
- Injuries arising from Interscholastic Activities as defined in this Policy;
- any Injury suffered by an Insured arising from travel that is neither authorized by the Institution nor paid for or subject to reimbursement by the Institution;
- any Injury suffered by an Insured 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;
- bio-feedback procedures;
- 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;
- acupuncture;
- Custodial Care;
- long term care service;
- private duty nursing services;
- intentional self-inflicted injury, except when the injury results from a medical condition or an act of domestic violence;
- expenses incurred for Injury arising out of or in the course of a Covered Person's employment, regardless if benefits are, or could be paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation;
- 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;

NON-DUPLICATION OF BENEFITS LIMITATION

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

CLAIM PROVISIONS

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

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

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

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

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

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 and accident report.

Payment of Claims

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

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

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

- If the Covered Person receives medical assistance from the State of Texas, the Insurer will pay any benefits based on his or her medical expenses to the Texas Department of Human Services, but not more than the actual cost that the Department pays for those expenses. Only the balance, if any, of such benefits will then be payable to the Covered Person.
- If the Covered Person is unable to execute a valid release, the Insurer can: (a) pay any Providers on whose charges the claim is based toward the satisfaction of those charges; or (b) pay any person or institution that has assumed custody and principal support of the Covered Person.
- If the Covered Person dies while any accrued benefits remain unpaid, the Insurer can pay any Provider on whose charges the claim is based toward the satisfaction of those charges. Then, any benefits that still remain unpaid can be paid to the Covered Person's beneficiary or estate.

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

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

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

Subrogation

We may recover any benefits paid under the Policy to the extent a Covered Person is paid for the same Injury by a third party, another insurer, or the Covered Person's uninsured motorist insurance (if the Covered Person did not pay the premiums for the uninsured motorist insurance coverage). 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 person paid of such overpayment and request reimbursement. However, should We not receive such reimbursement, We shall have the right to offset such overpayment against any other benefits payable under the Policy to the extent of the overpayment.

ADMINISTRATIVE PROVISIONS

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

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

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

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

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

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

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

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

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

ParPlan Provider Arrangement

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

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

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

- deductible, copayment(s), Coinsurance;
- limitations and exclusions; and
- maximums.

Notice of Termination of PPO Arrangement with Network Providers

If the Insurer terminates a PPO arrangement with a Network Provider, proper notice will be sent to Insureds advising them of the Insurer's termination and will make available a current listing of Network Providers. The Insurer's termination of a Network Provider, except for reasons of medical incompetence or unprofessional behavior, shall not release the Doctor from the generally recognized obligation to treat the Covered Person and to cooperate in arranging for appropriate referrals. Nor does it release the Insurer from the obligation to reimburse the Covered Person at the Network Provider rate if, at the time of the Insurer's termination of the Network Provider, the Covered person has special circumstances such as a disability, acute condition, or life-threatening illness or is past the 24th week of pregnancy and is receiving treatment in accordance with the dictates of medical practice. ("Special circumstances" means a condition such that the treating Doctor reasonably believes that discontinuing care by the treating Doctor could cause harm to the patient.) Special circumstances will be identified by the treating Doctor, who must request that the Covered Person be permitted to continue treatment under the Doctor's care and agree not to seek payment from the patient of any amounts for which the Covered Person would not be responsible if the Physician were still a Network Provider. The continuity of coverage under this provision will not be extended beyond 90 days of the effective date of the Insurer's termination of the Provider (beyond 9 months in the case of a Covered Person who has been diagnosed with a terminal illness). However, if the Covered Person, at the time of the Network Provider's termination, is past the 24th week of pregnancy, the continuity will be extended through delivery of the child, immediate post-partum care, and the follow-up checkups within the first 6 weeks of delivery.

GENERAL PROVISIONS

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

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

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

Policy Termination: We may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder. Either We or the Policyholder may terminate this Policy on any Premium Due Date by giving 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:

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

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

Examination of Records and Audit: We shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after final termination of the Policy as they relate to the premiums or subject matter of this insurance.

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

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

Misstatement of Age: In the event the age of a 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:

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

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

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

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

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

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, Potaeu, Pryor and some other communities
Oregon	Regence Blue Cross and Blue Shield of Oregon	State-wide
Pennsylvania	Capital Blue Cross Independence Blue Cross Highmark Blue Cross and Blue Shield (Independence Blue Cross, Capital Blue Cross and Blue Cross of Northeastern Pennsylvania) Highmark Blue Cross and Blue Shield Blue Cross of Northeastern Pennsylvania	State-wide
Rhode Island	Blue Cross and Blue Shield of Rhode Island	State-wide
South Carolina	Blue Cross and Blue Shield of South Carolina	State-wide
South Dakota	Wellmark Blue Cross and Blue Shield of South Dakota	State-wide
Tennessee	Blue Cross and Blue Shield of Tennessee	State-wide
Texas	Blue Cross and Blue Shield of Texas	State-wide
Utah	Regence Blue Cross and Blue Shield of Utah	State-wide
Vermont	Blue Cross and Blue Shield of Vermont	State-wide
Virginia	Anthem Blue Cross and Blue Shield of South East	State-wide, exclusive of Amherst, Appomattox, Campbell, Culpeper counties and the city of Lynchburg

Washington	Premera Blue Cross Regence Blue Shield Northwest Washington Medical Bureau	State-wide
West Virginia	Mountain State Blue Cross and Blue Shield	State-wide
Wisconsin	Blue Cross and Blue Shield United of Wisconsin	State-wide
Wyoming	Blue Cross and Blue Shield of Wyoming	Laramie County Only
Puerto Rico	TRIPLE S and La Cruz Azul de Puerto Rico	Island-wide

NOTICE TO BLUE CROSS AND BLUE SHIELD OF TEXAS

CONTRACTHOLDER

Out-of-Area Services

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

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

A. BlueCard® Program

Under the BlueCard® Program, when a Covered Person accesses covered healthcare services within the geographic area served by a Host Blue, Blue Cross and Blue Shield of Texas will remain responsible for fulfilling BCBSTX contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare Providers.

Whenever a Covered Person accesses Covered Services outside the Blue Cross and Blue Shield of Texas Service Area and the claim is processed through the BlueCard Program, the amount he/she pays for Covered Services is calculated based on the lower of:

- The billed covered charges for a Covered Person's Covered Services; or
- The negotiated price that the Host Blue makes available to BCBSTX.

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

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

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

B. Non-Participating Healthcare Providers Outside the BCBSTX Service Area

For Non-Participating healthcare Providers outside the Blue Cross and Blue Shield of Texas Service Area, please refer to the Allowable Amount definition in the **Definitions** section of this Policy.

NOTICE OF PRIVACY PRACTICES

We keep our members' financial and health information private as required by law, accreditation standards and our own policies. This Notice explains your rights, our legal duties and our privacy practices.

Your Financial Information

We collect and use several types of financial information to carry out insurance activities. This includes information that you give us on applications or other forms, such as your name, address, age, and dependents. We keep records about your business with our affiliates, others, or us such as insurance coverage, premiums, and payment history.

We use physical, technical, and procedural methods to protect your private information. We share it only with our employees, affiliates or others who need it to provide service on your policy, to do insurance business, or for other legally allowed or required purposes.

Your Health Information

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

We collect, use and communicate information about you for health care payment and operations or when we are allowed or required by law to do so.

For Payment: We use and disclose information about you to manage your account or benefits and to pay claims for health care you receive through your plan. For example, we keep information about your premium and Deductible payments. We may also give information to a doctor's office to confirm your benefits or we may ask a hospital for details about your treatment so that we may review and pay the claim for your care.

For Health Care Operations: We use and disclose information about you for our operations. For example, we may use information about you:

- To review the quality of care and services you receive;
- To provide you case management or care coordination services, such as for asthma, diabetes, or traumatic injury; or
- For quality or accreditation reviews.

We may contact you with information about treatment options or other health-related benefits and services. For example, when you or your dependents reach a certain age, we may notify you about other products or programs for which you may become eligible, such as Medicare supplements or individual coverage. We may also send you reminders about routine medical check-ups and tests.

If you are in a group health plan, we may share certain health information with the plan sponsor or other organizations that help pay for your membership in the plan to enroll you in the plan or so the plan sponsor can manage the health plan. Plan sponsors that receive this information are required by law to have controls in place to protect it from improper uses.

To Your Family or Person Designated by You: We may disclose your medical information, with your verbal permission and in circumstances where it is impracticable to get your written permission, to a family member or other person designated by you to the extent necessary to help with your health care or with payment for your health care. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in your care.

Before we disclose your medical information to a person involved in your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

As Allowed or Required by Law: Information about you may be shared for oversight activities required or allowed by law; for judicial or administrative proceedings; to public health authorities; for law enforcement purposes; to coroners, funeral directors or medical examiners (about decedents); for research purposes; to avert a serious threat to health or safety; for specialized government functions; for workers' compensation purposes and to respond to requests from the Secretary, US Department of Health and Human Services.

Authorization: We will get your written permission before we use or share your protected health information for any other purpose, unless otherwise stated in this notice. You may withdraw this permission at any time, in writing. We will then stop using your information for that purpose. However, if we have already used or shared your information based on your authorization, we cannot undo any actions we took before you withdrew your permission.

Your Rights

Under current federal privacy regulations, you have the right to:

- **See or get a copy of certain information that we have about you (contained in the Designated Record Set) or ask that we correct your personal information that you believe is missing or incorrect. If someone else (such as your doctor) gave us the information, we will let you know so you can ask them to correct it.**
- Ask us not to use your health information for payment or health care operations activities. We are not required to agree to these requests.
- Ask us to communicate with you about health matters using reasonable alternative means or at a different address if communications to your home address could endanger you.
- Receive a list of disclosures of your health information that we make on or after April 14, 2005, except when:
    - You have authorized the disclosure;
    - The disclosure is made for treatment, payment or health care operations; or
    - The law otherwise restricts the accounting.

Potential Impact of Other Applicable Law

The HIPAA Privacy Rule generally does not "preempt" (or override) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, if any state privacy laws or other applicable federal laws provide for a stricter privacy standard, then we must follow the more strict state or federal laws.

Complaints

If you believe we have not protected your privacy, you can file a complaint with us or with the Office for Civil Rights in the US Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact Information

If you want to exercise your rights under this notice or to talk with us about privacy issues or to file a complaint, please contact a Customer Service Representative at 1-855-267-0214.

Copies and Changes

You have the right to receive another copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

We reserve the right to change this notice. A revised notice will apply to information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever privacy notice is currently in effect. We will communicate any changes to our notice through subscriber newsletter.