

Blue Cross and Blue Shield of Texas
(herein called BCBSTX or Carrier)
Richardson, Dallas County, Texas

has issued this

**Experience Rated Group
Managed Health Care and
Prescription Drug Program Contract**
(herein called the Contract)

for the Employees of

United Independent School District
(herein called the Employer or Contractholder)

Contract Date (Initial): September 1, 2002
Contract Date (Restated): September 1, 2007

Group Number: 21673

to the Employer applying for this Contract and, subject to the terms of this Contract, agrees to provide the benefits detailed herein.

This Contract is issued in consideration of the *Request for Group Coverage* and of the timely payment of premiums as required herein. This Contract shall become effective on the Contract Date stipulated in the Schedule of Specifications and will be continued in effect by the payment of premiums at the rates determined by the Carrier in accordance with the provisions in **Premiums** until terminated as provided in **Termination of Coverage**, section A.

In Witness Whereof, the Carrier has caused this Contract to be executed at its Administrative Office in Richardson, Texas.



President of Blue Cross and Blue Shield of Texas

This is not a contract of Workers' Compensation insurance. The Employer does not become a subscriber to the Workers' Compensation system by purchasing this contract, and if the Employer is a nonsubscriber, the Employer loses those benefits which would otherwise accrue under the Workers' Compensation laws. The Employer must comply with the Workers' Compensation law as it pertains to nonsubscribers and the required notifications that must be filed and posted.

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

TABLE OF CONTENTS

Introduction	1
Article I – Definitions	2
Article II – Eligibility for Coverage; Effective Dates	4
Article III – Premiums	5
Article IV – Termination of Coverage	7
Article V – Replacement of Coverage	9
Article VI – General Provisions	11
Amendments/Notices (<i>inserts, as needed</i>)	
Schedule of Specifications	
Exhibit A – Plan Service Area Listing	
Benefit Booklet(s)	

Article I – Definitions

As used throughout the Contract:

Contract Anniversary means the month, day, and year specified in the Schedule of Specifications and the corresponding date in each year thereafter for as long as the Contract is in force.

Contract Date means the date on which coverage for the Large Employer’s Contract with BCBSTX commences.

Contract Month means each succeeding monthly period, beginning on the Contract Date.

Eligibility Date means the date the Participant satisfies the definition of either “Employee” or “Dependent” and is in a class eligible for coverage under this Contract, and:

1. For a new Employee, including any eligible Dependents to be covered, the date such Employee completes the number of days of continuous employment with the Large Employer (Waiting Period) as specified in the **Eligibility Requirements** section of the Schedule of Specifications, or
2. For a new Dependent of an Employee already having coverage under this Contract, the date the Employee acquired such Dependent.

Eligible Employee means an Employee who works on a full-time basis, who usually works at least 30 hours a week, and who otherwise meets the *Participation Criteria* established by a Large Employer. The term includes a sole proprietor, a partner, and an independent contractor, if the individual is included as an Employee under a Health Benefit Plan of a Large Employer regardless of the number of hours the sole proprietor, partner, or independent contractor works weekly, but only if the plan includes at least two other eligible employees who work on a full-time basis and who usually work at least 30 hours a week. *Participation Criteria* means any criteria or rules established by a Large Employer to determine the Employees who are eligible for enrollment or continued enrollment under the terms of a Health Benefit Plan. The *Participation Criteria* may not be based on Health Status Related Factors.

Employee means an individual employed by a Large Employer.

For purposes of this plan, the term *Employee* may also include those individuals who are no longer an Employee of the Large Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the *Texas Insurance Code*.

Health Status Related Factor means (1) health status, (2) medical condition, including both physical and mental illness, (3) claims experience, (4) receipt of health care, (5) medical history, (6) genetic information, (7) evidence of insurability, including conditions arising out of acts of family violence, and (8) disability.

Large Employer (hereafter called Employer) means a person (individual, corporation, partnership, or other legal entity) who employed an average of at least 51 Eligible Employees on business days during the preceding Calendar Year and who employs at least two Employees on the first day of the plan year.

Plan Service Area means the geographical area(s), used to determine eligibility for Managed Health Care Plan benefits.

1. The geographical area(s) documented in the attached **Exhibit A – Plan Service Area Listing**, shall be the Plan Service Area for Participants enrolled in the Managed Health Care coverage under this Contract.
2. If the Employee resides in the Plan Service Area, Managed Health Care Plan coverage will be available for him and all his Dependents. An Employee residing outside the Plan Service Area may elect Managed Health Care Plan coverage for himself and all of his Dependents if his place of employment is located within the Plan Service Area.

Article I – Definitions

3. An Employee residing outside of the Plan Service Area will be covered by Traditional Medical Benefit coverage that will be issued under a separate contract, when necessary.
4. Provider Network options elected by the Employer are indicated in the **Plan Service Area** section of the Schedule of Specifications.
5. Only Network Providers can provide or arrange for In–Network services under the Managed Health Care Plan provisions.
6. BCBSTX shall annually furnish Provider Network directories to each Employee enrolled under Managed Health Care coverage. These directories list names, locations, and other information specific to those Network physicians, hospitals, and other health care providers and facilities in the Plan Service Area.

Schedule of Specifications (Initial) or (Restated) (hereafter called the Schedule) means the Schedule attached hereto and made a part of this Contract, or the latest of any Schedule revised to replace one previously in effect, provided that if more than one Schedule of Specifications is in effect under this Contract, the term shall mean, for each Employee covered and for each Participant under his coverage, the Schedule of Specifications which has **Eligibility Requirements** that are applicable to such Employee.

INTRODUCTION

The Contract between the Employer and BCBSTX is written in three parts:

1. This document;
2. The Schedule of Specifications, with attached Exhibit A;
3. The Benefit Booklet(s) attached hereto; and

any applications, Schedule(s) of Coverage, enclosures, addenda, exhibits, and amendments to any of them.

This document contains those aspects of the Contract more specifically applicable to the Employer. The Benefit Booklet contains information more specifically applicable to Participants. In the event of any conflict between any components of this Plan, the Schedule of Specifications provided to the Employer by BCBSTX prevails.

Administration: General administrative matters affecting Participants are described in the Benefit Booklet.

Definitions: The defined terms affecting this Contract are capitalized and are explained in Article I of this document, as used throughout the Benefit Booklet, or in the **DEFINITIONS** section of the Benefit Booklet.

Benefits: Benefits for Inpatient Hospital Expenses, Medical–Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses are explained in the **COVERED MEDICAL SERVICES** section of the Benefit Booklet.

Benefits for Covered Drug expenses are explained in the **PRESCRIPTION DRUG PROGRAM** section of the Benefit Booklet.

Limitations and Exclusions:

Limitations and exclusions for Inpatient Hospital Expenses, Medical–Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses are explained in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of the Benefit Booklet.

Limitations and exclusions for the prescription drug program are explained in the **Limitations and Exclusions** section of the **PRESCRIPTION DRUG PROGRAM** portion of the Benefit Booklet.

Article II – Eligibility for Coverage; Effective Dates

A. Eligibility for Employee and Dependent coverage is described in the Benefit Booklet under **WHO GETS BENEFITS**.

B. **Application for Coverage**

Coverage of each eligible Employee or Dependent shall be contingent upon the Employee or Dependent making application in accordance with the approved procedures established by the Carrier. Coverage shall become effective on the date determined by the applicable provisions below.

C. **Effective Dates – Timely Application**

The provisions of this section C are applicable if the application for coverage is received by the Carrier within the first 31 days following the applicant's Eligibility Date. Coverage for any person whose application is received more than 31 days from the applicant's Eligibility Date shall become effective according to the provisions of *Effective Dates – Late Enrollee* and *Loss of Other Health Insurance Coverage* found in the Benefit Booklet.

If the application is for coverage of an Employee or an Employee and his eligible Dependents, and

1. If the Employee is eligible on the Contract Date and the application is received by the Carrier prior to or within 31 days following such date, coverage becomes effective on the Contract Date.
2. If the Employee enrolls for himself and an eligible Dependent during an Open Enrollment Period, coverage shall become effective on the Contract Anniversary date.
3. If the Employee becomes eligible after the Contract Date and if the application is received by the Carrier within the first 31 days following the Employee's Eligibility Date, the coverage shall become effective as specified in the **Effective Dates** section of the Schedule of Specifications.

D. **Annual Election of Coverage**

In the event the Employer offers multiple plan options to Employees and their Dependents, the Employee enrolled in this Health Benefit Plan may transfer coverage from one plan option to another plan option only during the Employer's Open Enrollment Period.

Article III – Premiums

- A. The premium rates initially effective shall be shown under **Premiums** in the Schedule, and continuance of the coverage shall be contingent upon payment of the premiums by the Employer at the Administrative Office of the Carrier in Richardson, Texas, in accordance with the following provisions: (1) the first premium is due on the Contract Date; (2) subsequent premiums are, during the continuance of this Contract, payable in advance. Any adjustments to premiums, prorated premium, or arrearage caused by either an effective date prior to a regular premium billing or a retroactive effective date shall be payable immediately upon receipt by the Employer of a billing by the Carrier. The Carrier may refuse to accept any payment which does not represent a total premium, or which is late. Any acceptance by the Carrier of a late or partial premium payment shall not be deemed a waiver of this section A in the event of any future failure of the Employer to make a timely or total payment of premium.
- B. If any portion of the premiums due under this Contract is required to be paid by any covered Employee or Dependent, the Employer agrees to collect such amounts due on the Employee's behalf as their agent, and to pay over such funds to the Carrier as part of the total premium due. The Employer shall not act as an agent of the Carrier with regard to such collections, and no premium will be considered to have been paid until actually received and accepted by the Carrier.
- C. Premiums may be paid on a monthly, quarterly, semiannual, or annual basis as the Employer may elect, but without discount.
- D. The premium to be paid shall be determined by multiplying the number of Employees covered for each classification by the rate then applicable for that classification, and totaling the extensions thus obtained.
1. Premiums **will be** billed for the entire month for Participants with effective dates on the first through the fifteenth day of the month. Premiums **will not** be billed for the month when the Participant's effective date falls on the sixteenth day through the end of the month.
- E. This Contract shall be nonassessable and does not share in the earnings of the Carrier. The Carrier shall have the right to change the premium rates on any premium due date occurring after the period of time for which the premium rates are to be in effect as indicated in the **Premiums** section of the Schedule, or any amendment, revision, or replacement of such **Premiums** section made in writing.
- Any such change shall be made uniformly applicable to all Employees within any subgroup or other classification under this Contract.
- Notwithstanding the foregoing paragraphs of this section E, premium rates may be changed at any time by mutual agreement between the Carrier and the Employer.
- F. The Carrier reserves the right to change the premium rates:
1. On any Contract Anniversary, provided not less than sixty (60) days before the date on which a premium rate increase takes effect, BCBSTX shall give prior written notice to the Employer of the amount of such increase and the date on which the increase is to take effect; or
 2. If a *substantial change* occurs in the number or composition of Employees covered, which results from:
 - a. The addition of an alternative health benefit plan such as a health maintenance organization, an alternative prescription drug plan, or preferred provider organization; or
 - b. A change in the benefit specifications provided under this Contract; or

Article III – Premiums

- c. A change in contribution level or other consideration paid by the Employer; or
- d. The opening or closing of any offices or facilities or any layoffs in the workforce by the Employer; or
- e. The sale, acquisition, or merger of the Employer's company by or with another company; or
- f. The purchase or acquisition of another company by the Employer's company; or
- g. Filing for bankruptcy or reorganization under state or federal law by the Employer.

A *substantial change* will be deemed to have occurred when the number of Employees covered changes by:

- 1. 10% or more over a 30-day period; or
- 2. 25% or more over a 90-day period; or
- 3. falling below the specifications shown in the **Minimum Enrollment Requirements** provision of the Schedule of Specifications for a period of six consecutive months.

In any such event, the Carrier reserves the right to adjust premium rates on any premium due date occurring between the date such *substantial change* is identified and the next Contract Anniversary. Not less than sixty (60) days before the date on which a premium increase takes effect, the Carrier shall give written notice to the Employer of the amount of such increase and the date on which the increase is to take effect.

- G. Any premium amounts due shall automatically be increased by the amount of any taxes imposed, increased, or adjudged due by any lawful authority on or after the Contract Date which the Carrier is required to pay or remit, whether relating to fees, services, benefits, payments, or any other aspect of this Contract.

Article IV – Termination of Coverage

The termination provisions of this Contract shall be as described in this document and the Benefit Booklet.

- A. The coverage of all Participants hereunder shall automatically terminate when this Contract is terminated in any manner, as follows:
1. By cancellation on any premium due date, at the request in writing of the Employer furnished to the Carrier at its Administrative Office, not less than 30 days in advance;
 2. If this Contract is replaced by another Blue Cross and Blue Shield of Texas contract;
 3. By default in premium payment, as required in Article III, on the last day of the last period for which the entire group premium is paid; provided, however, any failure of the Carrier to terminate coverage shall not be deemed a waiver of this subsection in the event of any future default in premium payment;
 4. The Employer commits fraud or intentional misrepresentation of a material fact;
 5. No enrollee in connection with the Plan resides or works in the service area of the Carrier or in the area for which the Carrier is authorized to do business;
 6. Upon non-renewal, in the event of failure to maintain the minimum enrollment requirements shown in the Schedule of Specifications, for a period of six consecutive months; or
 7. If the Employer has not complied with the terms of the Health Benefit Plan.
- B. The coverage of any Employee and his Dependents included hereunder shall terminate:
1. Subject to the provisions in item B(4), below, on the last day of the last period for which his portion of the group premium is paid to the Carrier. The Employer may terminate the coverage of any Employee on the last day of any Contract Month for which premiums for such Employee have been received by the Carrier and any premiums for such Employee that are applicable to succeeding Contract Months will be refunded by the Carrier to the Employer upon request, if the Employer has paid premium on a quarterly, semiannual, or annual basis.
 2. The effective date of an amendment to this Contract, issued at the direction of the Employer, that terminates the coverage of any class of Employees to which he belongs;
 3. Subject to the provisions in item B(4), below, on the last day of the Contract Month during which the Employee ceases to be an Employee as defined in Article I of this Contract and is not eligible to retain Employee status under any employer benefit plan(s) created in accordance with the Employer's established procedures whereby individual selection by the Employer or the Employee to be included under such plan(s) is precluded.
 4. As provided under state law, the Employer will be liable for the individual's premiums from the time the individual is no longer part of the group eligible for coverage under the Contract until the end of the Contract Month in which the Employer notifies BCBSTX that the individual is no longer part of the group eligible for coverage under the Contract and the individual will remain covered under the Contract until the end of that period. Notwithstanding the foregoing, if an individual ceases to be eligible within the last (7) calendar days of a Contract Month and the Employer notifies BCBSTX of such loss of eligibility within the first three (3) business days of the subsequent Contract Month, the individual's coverage shall terminate on the last day of the Contract Month in which the individual lost eligibility.

Article IV – Termination of Coverage

- C. Subject to the provisions in item B(4), above, the coverage of any Dependent of an Employee included hereunder shall terminate at the end of the Contract Month in which such Dependent ceases to be a Dependent, as defined in the Benefit Booklet, regardless of the knowledge of such fact by the Carrier or the Employer.

In the event termination of coverage is due to death of a Dependent, the Carrier will refund to the Employer premiums paid for the Dependent for Contract Months subsequent to the date of death, up to 24 Contract Months prior to notification to the Carrier of the death.

In the event termination of coverage is for any other reason, refund to the Employer of premiums paid for the Dependent for Contract Months subsequent to the date of coverage termination shall be limited to Contract Months following the date of notification to the Carrier of the termination of the Dependent, if the Employer has paid premium on a quarterly, semiannual, or annual basis.

- D. Under no circumstances shall the Carrier be obligated to notify any Participant of the termination of this Contract or of his coverage hereunder.
- E. Notwithstanding the above provisions of this Article IV, if the Employer is paying an Employee's premiums in whole or in part pursuant to the terms of a collective bargaining agreement and in the event of cessation of work as the result of a labor dispute by its Employees who are members of the bargaining unit, coverage under this Contract for such Employees and their Dependents hereunder shall terminate on the last day of the Contract Month in which such cessation of work began subject to the provisions in B(4), above; except that coverage under this Contract may be continued for such Employee and Dependents for a period of up to six additional Contract Months, provided that for each such additional Contract Month:
1. Coverage of at least 75% of the Employees, who are members of the bargaining unit and who cease working due to the labor dispute, is maintained; and
 2. A single payment for the premiums due from such Employees is remitted for such premium payment.

The Carrier reserves the right to adjust premium rates by any amount up to 20% for such Employees which shall be payable for such additional Contract Months.

Article V – Replacement of Coverage

A. If this Contract replaces prior BCBSTX coverage issued to the Employer:

1. Benefits for Eligible Expenses incurred during a Hospital Admission or an admission in a Facility Other Provider which were incurred while the prior coverage was in effect and continuing after the Contract Date shall be provided in accordance with the terms of the prior coverage until the Participant is discharged from the facility, as though the prior coverage had remained in effect; and
2. The benefits available under this Contract shall be effective on and after the Contract Date. If the prior coverage was BCBSTX major medical coverage, no further major medical benefits shall be available after the Contract Date except as specified above.

Any expenses incurred by a Participant under the prior coverage in the same Calendar Year preceding the Contract Date and applied toward satisfaction of the Deductible under that coverage, will be applied toward satisfaction of the Calendar Year Deductible of this Contract.

If this Contract replaces prior BCBSTX coverage issued to the Employer and the prior BCBSTX coverage included an Upfront Deductible and the replacement coverage includes an Upfront Deductible: any expenses incurred by a Participant in the same Calendar Year preceding the Contract Date and applied toward satisfaction of the Upfront Deductible under that coverage, will be applied toward the satisfaction of the Upfront Deductible of this coverage.

If this Contract replaces prior BCBSTX coverage issued to the Employer and the prior BCBSTX coverage did not include an Upfront Deductible but did include a Calendar Year Deductible: any expenses incurred by a Participant under the prior coverage in the same Calendar Year preceding the Contract Date and applied toward satisfaction of the Calendar Year Deductible, will not be applied toward satisfaction of the Upfront Deductible of this Contract but will be applied toward the Calendar Year Deductible of this coverage.

If this Contract replaces prior BCBSTX coverage issued to the Employer and the prior BCBSTX coverage did include an Upfront Deductible but the replacement coverage does not include an Upfront Deductible: any expenses incurred by a Participant under the prior coverage in the same Calendar Year preceding the Contract Date and applied toward satisfaction of the Upfront Deductible, will not be applied toward satisfaction of any Calendar Year Deductible of this coverage.

Coinsurance Amounts for Eligible Expenses incurred by a Participant under the prior coverage in the same Calendar Year and preceding the Contract Date which were applied to the Coinsurance Stop–Loss Amount will be applied toward the Coinsurance Stop–Loss Amount of this Contract.

B. If this Contract replaces prior coverage of the Employer, the following replacement of medical coverage provisions shall apply to each Participant who was covered under the Employer’s Health Benefit Plan immediately prior to the Contract Date of this coverage and who is eligible to participate under this Contract:

1. Any expenses incurred by a Participant in the same Calendar Year preceding the Contract Date, which will qualify as Eligible Expenses under this Contract, and which were applied toward satisfaction of the Calendar Year Deductible of the prior coverage, will be applied toward satisfaction of the Calendar Year Deductible of this Contract, provided the Participant submits proof of such Eligible Expenses satisfactory to BCBSTX in accordance with BCBSTX’s procedures.
2. Any Coinsurance Amounts for expenses incurred by a Participant in the same Calendar Year preceding the Contract Date, will be credited toward the Coinsurance Stop–Loss Amount of this Contract, provided the Participant submits proof of such Coinsurance Amounts satisfactory to BCBSTX in accordance with BCBSTX’s procedures.

Article V – Replacement of Coverage

3. Benefits are not available for expenses incurred prior to the Contract Date or for any services or supplies provided during the course of a Hospital Admission or an admission in a Facility Other Provider which were incurred prior to the Contract Date.
4. Benefits will be available for Eligible Expenses incurred on and after the Contract Date.
5. In no event will coverage be continued beyond the date it would otherwise terminate under the terms of this Contract.

Article VI – General Provisions

- A. **Applicable Law:** This Contract is issued in Texas and is subject to Texas choice of law rules. All disputes arising under this Contract between BCBSTX and the Contractholder shall be resolved in Texas.
- B. **Certificate:** The Carrier will issue to the Employer for delivery to each covered Employee a certificate setting forth a statement of the essential features of the insurance coverage of such Employee or Participant, and to whom the benefits are payable.
- C. **Compliance with Laws and Regulations:** BCBSTX and Employer will comply with applicable state and federal laws and regulations regarding confidentiality or privacy of records and other information and to cooperate to ensure such compliance.
- D. **Coverage Data:** The Employer shall furnish the Carrier all information needed to effect coverage of Employees and Dependents hereunder and termination and changes in such coverage on a timely basis.
- E. **Disclaimer:** The Carrier shall not be liable for any act or omission by any Hospital, Physician, or Other Provider, their agents or employees, in caring for a Participant receiving services covered under this Contract, and no responsibility attaches hereunder for inability of any Hospital, Physician, or Other Provider to furnish accommodations or services. Benefits are subject to the rules and regulations of the Hospital, facility or other institution selected by the Participant, and are available only for sickness or injury acceptable to such Hospital, facility, or other institution.
- F. **Electronic Exchange of Data:** In the event the Employer and Carrier exchange data and information electronically, the Employer agrees to transfer on a timely basis all required data to the Carrier via electronic transmission on the intranet and/or internet or otherwise, in the format specified by the Carrier, a copy of which shall be furnished to the Employer upon written request to the Carrier. The Employer authorizes the Carrier to submit such data and information in the specified electronic format. In the event the Employer is unable or unwilling to transfer data in the specified electronic format, the Carrier is under no obligation to receive or transmit data in any other format.

The Employer agrees to indemnify and hold harmless the Carrier from any and all liability arising out of the transfer of such data from the Employer to the Carrier or from the Carrier to the Employer. This indemnification also covers claims and or liability arising out of erroneous, misdirected, intercepted, incomplete or otherwise defective information and transfers of information including, but not limited to, garbled transmissions, transmissions to third parties, and intercepted transmission. If such transmissions occur, Carrier and the Employer agree to redirect the information via another mutually agreeable means.

- G. **Entire Contract:** This document and its Schedule(s) of Specifications, any applications, the Benefit Booklet(s), Schedule(s) of Coverage, and any exhibits, enclosures, addenda and amendments to any, shall constitute the entire Contract; and, in the absence of fraud, all statements made by the Employer or by the person insured shall be deemed representations and not warranties. No statement shall be used in any contest or in defense of a claim hereunder unless a copy of the instrument containing the statement is or has been furnished to such person, or in the event of death or incapacity of the insured person, to the individual's beneficiary or personal representative. No change in this Contract shall be valid until approved by an executive officer of BCBSTX and unless such approval is attached by amendment, rider or otherwise provided in writing in this document. No agent has the authority to change this Contract or to waive any of its provisions.

Article VI – General Provisions

- H. **Incontestability:** This Contract shall be incontestable after it has been in force for two years from date of its issue except for nonpayment of premiums. In the absence of fraud, no statement made by any person covered under this Contract relating to his insurability shall be used in contesting the validity of the coverage with respect to which such statement was made after such coverage has been in force prior to the contest for a period of two years during such person's lifetime unless it is contained in a written instrument signed by him; provided, however, this provision shall not limit any defense of such claim based on provisions in the Contract: (1) relating to eligibility for coverage; (2) relating to coordination of benefits; or (3) limiting the amounts of recovery from all sources to no more than 100% of the total actual losses incurred.
- I. **Legal Actions:** No action at law or in equity shall be brought to recover on this Contract prior to the expiration of 60 days after written Proof of Loss has been filed in accordance with the requirements herein and no such action shall be brought at all unless brought within three years from the expiration of the time within which written Proof of Loss is required to be furnished by this Contract.
- J. **Medicare/Primary Carrier Determinations:** Any exclusions of benefits in this Contract for services or supplies for which benefits are paid or payable under governmental programs and the definition of "Plan" in the **Coordination of Benefits** section of the Benefit Booklet shall not be applicable to Medicare Part A and Part B benefits for those Employees who the Employer determines are Employees for whom the Employer's benefit plan is required to be primary to Medicare by the Age Discrimination in Employment Act (ADEA) for the period of time such primary coverage is so required. This provision shall also be applicable to Dependent spouses of Employees so designated for the period of time, if any, that the spouse's coverage under the Employer's benefit plan is also required to be primary to Medicare.
- The same exclusions and definition of "Plan" described above are not applicable to Medicare Part A and Part B benefits for Participants during the period specified by Medicare's regulations for secondary payer for treatment of end-stage renal disease due to kidney transplant or self-dialysis training of Medicare entitlement by reason of renal dialysis.
- K. **Misstatement of Age:** In the event: (1) premiums are based on the Participant's age; and (2) the age of a Participant has been misstated, the premium rate for such person shall be determined according to the correct age as provided in this Contract and there shall be an equitable adjustment of premium rate made so that the Carrier shall be paid the premium rate at the true age of the Participant.
- L. **Misstatement of Enrollment:** In the event the Employer furnishes the Carrier with enrollment information and premiums for persons who are not eligible for coverage under this Contract as bona fide Employees or Dependents, the Carrier may retroactively or currently cancel the coverage of such persons after the Carrier learns of such persons' failure to qualify as Employees or Dependents. The Carrier shall return all premiums for the period for which coverage is canceled.
- M. **Physical Examinations and Autopsy:** The Carrier shall have the right and opportunity to examine the person of the Participant for whom claim is made, when and so often as it may reasonably require during the pendency of a claim hereunder and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.
- N. **Refund of Benefit Payments:** If and when the Carrier determines that benefit payments hereunder have been made erroneously but in good faith, the Carrier reserves the right to seek recovery of such benefit payments from the Participant, any other insurance company, or Provider of services to whom such payments were made. The Carrier reserves the right to offset subsequent benefit payments otherwise available by the amount of any such overpayments. Any refund of benefits will not be credited to the Employer's claims experience until actual recovery is made.

Article VI – General Provisions

- O. **Reinstatement:** If default be made in the premium payments for this Contract, the subsequent acceptance of such premium by the Carrier or any of its duly authorized agents shall fully reinstate the Contract. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of the Contract shall not be deemed a waiver of either the Employer's requirement of timely premium payment or the Carrier's right of termination for default in premium payment in the event of any future failure of the Employer to make timely premium payments.
- P. **Separate Entities:** The Employer, on behalf of itself and its Participants, understands that this policy constitutes a contract solely between the Employer and Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX is a division of Health Care Service Corporation, A Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the Association).

The license from the Association permits BCBSTX to use the Blue Cross and Blue Shield Service Marks in the State of Texas. BCBSTX is not contracting as the agent of the Association. Said Employer also understands that it has not entered into this policy based upon representations by any person other than BCBSTX. No person, entity, or organization other than BCBSTX shall be held accountable or liable to the Employer for any of BCBSTX's obligations to the Employer created under this policy. This paragraph shall not create any additional obligations whatsoever on the part of BCBSTX other than those obligations created under other provisions of this policy.

- Q. **Time of Payment of Claims:** Benefits available under this Contract for any loss will be paid not more than 60 days after receipt of written Proof of Loss.
- R. **Verification of Eligibility:** Upon written request by BCBSTX, the Employer shall provide such business records and other information in its possession to verify to BCBSTX a person's eligibility status. Such verification may be required prior to or after the Effective Date of coverage of a person, or after coverage has terminated. Such records and information may include, but are not limited to, birth and divorce documents retained by the Employer, reports to the Texas Workforce Commission, Workers' Compensation reports, or Federal FICA and withholding tax records.

AMENDMENTS

NOTICES

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 Insureds or 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)."

NOTICE TO BLUE CROSS AND BLUE SHIELD OF TEXAS CONTRACTHOLDER

BlueCard

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

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

Liability Calculation Method Per Claim

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

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

- (i) The actual price paid on the claim by the Host Blue to the health care Provider (“Actual Price”), or
- (ii) An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue’s health care Providers or one or more particular Providers (“Estimated Price”), or
- (iii) An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue’s average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers (“Average Price”). An Average Price may result in greater variation to the Participant and the Contractholder from the Actual Price than would an Estimated Price.

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

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

Return of Overpayments

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

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

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service 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*, Article 21.28–D.)

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

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- Up to a total of \$200,000 for one or more policies for each individual covered.

Life Insurance:

- Net cash surrender value up to a total of \$100,000 under one or more policies on any one life; or
- Death benefits up to a total of \$300,000 under one or more policies on any one life.

Individual Annuities:

- Net cash surrender amount up to a total of \$100,000 under one or more policies owned by one contractholder.

Group Annuities:

- Net cash surrender amount up to \$100,000 in allocated benefits under one or more policies owned by one contractholder; or
- Net cash surrender amount up to \$5,000,000 in unallocated benefits under one contractholder regardless of the number of contracts.

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

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439

Blue Cross and Blue Shield of Texas
(herein called BCBSTX or Carrier)

Richardson, Dallas County, Texas

has issued this

Schedule of Specifications

(Restated)

(herein called the Schedule)

for the

**Experience Rated Group
Managed Health Care and
Prescription Drug Program Contract**
(herein called the Contract)

for the Employees of

United Independent School District
(herein called the Employer or Contractholder)

Contract Date (Initial): September 1, 2002
Contract Date (Restated): September 1, 2007

Group Number: 21673

This Schedule of Specifications constitutes an amendment in the entirety of the previous Schedule of Specifications and is not a termination as described under Article IV – Termination of Coverage in the Contract. The specifications of the previous Schedule of Specifications and all modifications, amendments, and changes made thereto are incorporated herein. All provisions of the original Schedule of Specifications, where applicable, remain in full force and effect except as modified, amended, or changed herein.

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

SCHEDULE OF SPECIFICATIONS (RESTATED)

Mandated Offers

The Carrier has offered Texas mandated benefits to the Employer as follows:

Home Health Care Services (60 Visits) <input type="radio"/> Accepted <input checked="" type="radio"/> Declined/Rejected (Refer to Extended Care Expense Benefits)	Speech and Hearing Therapy Services (Covered same as any other illness, including hearing aids) <input type="radio"/> Accepted <input checked="" type="radio"/> Declined/Rejected (Refer to Speech and Hearing Therapy Services)	In Vitro Fertilization Services Covered <input type="radio"/> Accepted <input checked="" type="radio"/> Declined/Rejected
---	---	--

Eligibility Requirements

Waiting Period

Employees continuously employed for not less than 0 days.

Dependent Age Limit

Limiting age of Dependent children is age 25.

Effective Dates

The effective dates of individual applications are to be handled under the terms of Option 35.

Option 35 means coverage shall become effective on the Employee's Eligibility Date – Premiums are billed from the first of the month for coverage effective on days 1 through 15 of the month or the first of the next month for coverage effective on days 16 through 31 of the month.

Plan Service Area

The PPO Network elected by the Employer:

BlueChoice[®] Network

Medical Coverage Factors for Managed Health Care Benefits

Inpatient Hospital Expense Benefits

- a. Deductible each admission (per-admission Deductible)

In-Network	Out-of-Network
\$100	\$500

- b. Benefit percentage and penalty for failure to preauthorize

In-Network	Out-of-Network
80% of Allowable Amount after per-admission Deductible	60% of Allowable Amount after per-admission Deductible
No Penalty	\$250 Penalty

Medical-Surgical Expense Benefits

- a. Calendar Year Deductible – per individual each Calendar Year

In-Network	Out-of-Network
\$300	\$600

- b. Calendar Year Deductible – per family each Calendar Year

In-Network	Out-of-Network
\$900	\$1800

- c. Three-month Deductible carryover provision applies

- d. Copayment Amounts

Services	In-Network	Out-of-Network
Physician Office Visit/Consultation	\$25	None
Outpatient Hospital Emergency Room visit	\$150	\$150

e. Benefit percentage

Services	In-Network	Out-of-Network
Physician office visit/consultation	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Emergency Care and Treatment of Accidental Injury within 48 hours Facility charges Physician charges	80% of Allowable Amount after \$150 outpatient Hospital emergency room Copayment Amount, waived if admitted 80% of Allowable Amount after Calendar Year Deductible	
Emergency Room Treatment Non-Emergency Care Facility Charges Physician Charges	80% of Allowable Amount after \$150 outpatient Hospital emergency room Copayment Amount, waived if admitted 80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after \$150 outpatient Hospital emergency room Copayment Amount, waived if admitted, and after Calendar Year Deductible 60% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance	80% of Allowable Amount after Calendar Year Deductible	
Other Medical-Surgical Expense	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

Extended Care Expense Benefits

a. Skilled Nursing Facility – maximum benefit each Calendar Year

In-Network	Out-of-Network
100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
\$10,000	

b. Home Health Care– maximum benefit each Calendar Year

In-Network	Out-of-Network
100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
\$10,000	

c. Hospice Care – maximum lifetime benefit

In-Network	Out-of-Network
100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
\$20,000	

Coinsurance Stop-Loss Amount

a. Coinsurance Stop-Loss Amount – per individual

In-Network	Out-of-Network
\$2000	\$6000

b. Coinsurance Stop-Loss Amount – per family

In-Network	Out-of-Network
\$6000	\$12000

Preexisting Conditions

Preexisting Conditions will be covered after a waiting period of 12 months.

Preexisting Conditions for Late Enrollees will be covered after a waiting period of 12 months.

Maximum Lifetime Benefits

Amount available to each Participant \$2,000,000

Special Provisions Expenses

Maternity Care Benefits

Dependent children are eligible for Maternity Care Benefits

In vitro fertilization services are not covered

Mental Health Care Benefits

a. Benefit percentage for Inpatient Hospital Expense

Hospital Services (Facility)	In-Network	Out-of-Network
Benefit Percentage	80% of Allowable Amount after per-admission Deductible	60% of Allowable Amount after per-admission Deductible
Number of Days	30 days	

b. Benefit percentage for Medical-Surgical Expense

Services	In-Network	Out-of-Network
Physician Inpatient Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Inpatient Number of Visits	30 visits	
Office Visit	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Professional Provider/Facility	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Outpatient Number of Visits	30 visits	

Serious Mental Illness Benefits

Benefits paid on the same basis as any other illness (with no day or visit limits).

Preventive Care Benefits

Benefit percentage for Medical–Surgical Expense

Services	In–Network	Out–of–Network
Physician office visit/consultation for routine physicals, well baby care, immunizations for Participants age 6 and over, hearing exams and vision exams	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible

Childhood Immunization Benefits

Childhood immunization benefits paid at 100% of Allowable Amount from birth through the date the child turns six years of age

Speech and Hearing Therapy Services Benefits

Benefits for Speech and Hearing Therapy Services, including hearing aids, are paid same as any other sickness – hearing aids limited to \$1000 maximum benefit in a 36–month period.

Prescription Drug Coverage Factors

Prescription Drug Program

RX Enhanced Program

Retail Prescription Drug Program

3-Tier

- 1. Generic Drug Copayment Amount \$5
- 2. Preferred Brand Name Drug Copayment Amount \$30
- 3. Non-Preferred Brand Name Drug Copayment Amount \$50
- 4. Limitations on Quantities Dispensed-Day Supply applies.

Mail Service Prescription Drug Program

3-Tier

- 1. Generic Drug Copayment Amount \$10
- 2. Preferred Brand Name Drug Copayment Amount \$60
- 3. Non-Preferred Brand Name Drug Copayment Amount \$100
- 4. Limitations on Quantities Dispensed-Day Supply applies.

Contract Date

The Contract Date(Restated) is September 1, 2007. The next Contract Anniversary shall be September 1, 2008, whether or not the two dates are separated by twelve months.

Minimum Enrollment Requirements

As an express condition of the Contract applied for, the Employer certifies that N/C (NO CHANGE) Employees are initially eligible to make application for coverage at the date of the Employer's *Request for Coverage*, and agrees that N/C% of that number N/C Employees must make application for coverage before the original Contract Date, otherwise the Employer's *Request for Coverage* shall be deemed to have been withdrawn. The Employer further agrees as an express condition of the Contract that at least N/C% of all Employees eligible for coverage at any point in time shall continue to be covered under the Contract, and that all persons for whom applications are to be submitted by the Employer are bona fide Employees or Dependents of Employees.

The preceding paragraph is a combined amount applicable to In–Network and Out–of–Network coverage.

Premiums

The Employer will provide payroll deduction facilities for the Employee's portion of the premium and make consolidated group premium remittances. The following shall be the monthly premium rates:

<u>Employee</u>	<u>Employee/Spouse</u>	<u>Employee/Child or Children</u>	<u>Employee/Family</u>
\$ 292.58	\$ 585.16	\$ 474.68	\$ 819.75

The above initial monthly premium rates shall be in effect beginning on September 1, 2007, and are subject to change by the Carrier after (a) the premium rates are in effect for a period of at least 12 Contract Months and/or (b) there is a *substantial change* in the number of covered Employees. (Refer to **Article III – Premiums** in the Contract.)

Employer Contribution

The amount of the Employer contribution shall be in accordance with the Employer's established procedures.

Special Provisions

The attached Special Provisions (and any Amendments) shall be considered a part of this Schedule of Specifications:

The Contract and the coverage provided thereunder shall become effective on the Contract Date stipulated under **Contract Dates**, provided that: (1) this Schedule of Specifications is executed in duplicate; (2) payment of the first month's premium is received by Blue Cross and Blue Shield of Texas; and (3) in the event of any alteration of this Schedule of Specifications, such alteration is accepted in writing by Blue Cross and Blue Shield of Texas.

Group Name United Independent School District

City, State Laredo, Texas

Group Executive Signature _____

Title _____

Date Signed: _____

By:  _____

President of Blue Cross and Blue Shield of Texas

EXHIBIT A

PLAN SERVICE AREA LISTING

for

**MANAGED HEALTH CARE
BENEFIT COVERAGE
(In–Network and Out–of–Network Benefits)**

Effective Date: September 1, 2007

The information provided in this Exhibit is current as of the effective date indicated above; however, additions and deletions may occur at any time in accordance with policies and procedures determined by the individual Blue Cross and/or Blue Shield Plan represented.

STATE	BLUE CROSS AND/OR 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	CareFirst Blue Cross and Blue Shield (DC)	Washington, D. C. metropolitan area and surrounding counties
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	Anthem Blue Cross and Blue Shield (Maine)	State-wide

STATE	BLUE CROSS AND/OR BLUE SHIELD PLAN	PLAN SERVICE AREA
Maryland	CareFirst 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		No PPO Network Available
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 the 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	BlueCross BlueShield 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

STATE	BLUE CROSS AND/OR BLUE SHIELD PLAN	PLAN SERVICE AREA
Pennsylvania	Capital Blue Cross Independence Blue Cross Highmark Blue Cross and Blue Shield <i>(Independence Blue Cross, Capital Blue Cross and Blue Cross of Northeastern Pennsylvania)</i> 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	Trigon Blue Cross and Blue Shield	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 & Blue Shield United of Wisconsin	State-wide, exclusive of some rural areas
Wyoming	Blue Cross and Blue Shield of Wyoming	Laramie County, only
Puerto Rico	TRIPLE S	Island-wide