November 2012

Webb County

Group #60256

SCHEDULE OF COVERAGE – PLAN 700

Plan Provisions	In–Network Benefits	Out–of–Network Benefits
Deductibles		
• Calendar Year Deductible *Three–month Deductible carryover applies*	$500 – per individual $1,500 – per family	$750 – per individual $2,250 – per family
Co–Share Stop–Loss Amounts	$2,000 – per individual $6,000 – per family	$4,000 – per individual $12,000 – per family
Copayment Amounts Required		
• Physician office visit/consultation	$25 Physician office visit	Does Not Apply
• Outpatient Hospital Emergency Room/Treatment Room visit	$75 outpatient Hospital Emergency Room/Treatment Room visit	$75 outpatient Hospital Emergency Room/Treatment Room visit
Maximum Lifetime Benefits per Participant	Unlimited	
Inpatient Hospital Expenses (Preauthorization is required) All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	90% of Allowable Amount No penalty for failure to preauthorize services	70% of Allowable Amount $250 penalty for failure to preauthorize services
Medical–Surgical Expenses		
• Office visit/consultation including lab and x–rays • Allergy Injections (with office visit)	100% of Allowable Amount after $25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
• Inpatient visits and Certain Diagnostic Procedures • Home Infusion Therapy (Preauthorization is required) • Physician surgical services in any setting	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
• Allergy Injections (without office visit)	100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible
• Independent Lab & X–ray	100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE – PLAN 700

Plan Provisions	In–Network Benefits	Out–of–Network Benefits
Extended Care Expenses (Preauthorization is required)		
• Skilled Nursing Facility Combined 25 visits per Calendar Year	100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible
• Home Health Care Combined 60 visits per Calendar Year	100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible
• Hospice Care Unlimited	100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible
Behavioral Health Services		
Serious Mental Illness (Preauthorization is required)		
Inpatient Services		
• Hospital services (facility)	90% of Allowable Amount	70% of Allowable Amount
• Physician services	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
• Behavioral Health Practitioner Expenses (office setting)	100% of Allowable Amount after $25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
• Other Outpatient Services	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Mental Health Care/Treatment of Chemical Dependency (Preauthorization is required)		
Inpatient Services		
• Hospital Services (facility)	90% of Allowable Amount	70% of Allowable Amount
• Physician Services	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
	Limited to 30 inpatient days/visits each Calendar Year	
Outpatient Services		
• Behavioral Health Practitioner Expenses (office setting)	100% of Allowable Amount after $25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
• Other Outpatient Services	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
	Limited to 30 visits each Calendar Year	
Chemical Dependency Lifetime Maximum	3 separate series of treatment for each covered individual	

SCHEDULE OF COVERAGE − PLAN 700

Plan Provisions	In−Network Benefits	Out-Of-Network Benefits
Emergency Care Accidental Injury & Emergency Care (Including Accidental Injury & Emergency Care for Behavioral Health Services)		
• Facility Charges	90% of Allowable Amount after $90 outpatient Hospital emergency room Copayment Amount (waived if admitted)	
• Physician Charges	90% of Allowable Amount after Calendar Year Deductible	
Non−Emergency Care (including Non-Emergency Care for Behavioral Health Services)		
• Facility Charges	90% of Allowable Amount after $90 outpatient Hospital emergency room Copayment Amount (waived if admitted)	70% of Allowable Amount after $90 outpatient Hospital emergency room Copayment Amount (waived if admitted) and Calendar Year Deductible
• Physician Charges	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	90% of Allowable Amount after Calendar Year Deductible	
Preventive Care		
• Routine physical examinations, well baby care, immunizations 6 years & over, and routine lab, x−ray, vision and hearing exams	100% of Allowable Amount after $25 Copayment Amount for Physician Office Visit	70% of Allowable Amount after Calendar Year Deductible
• Immunizations Birth up to age 6	100% of Allowable Amount Deductible waived	100% of Allowable Amount Deductible waived
Benefitsf or Tests for Colorectal Cancer − All Places of treatment and diagnoses	100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible
Speech and Hearing Services, excluding hearing aids	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Chiropractic Services	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
	Limited to 35 visits each Calendar Year	
Physical Medicine Services	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the 12–month period following the Participant's initial Effective Date or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired). Credit will be given for time served under Creditable Coverage.

Preexisting Conditions for Dependent children under age 19 and all other eligible individuals under age 19 will be covered without any waiting periods.

Waiting Period

First of the month following 30 days

TEXAS ASSOCIATION of COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL

Custom Prescription Drug Program
For
Webb County

Prescription Drug Program *(Copayments will not apply to Co-Share Stoploss Maximum)*	*Network*
Retail Pharmacy	*Participating CVS Caremark Retail Pharmacy*
Deductible	*$0 Individual /* *$0 Family*
Non-Preferred Brand Name Drug	*$40 Copayment Amount* *(When no generic is available or Rx is prescribed Dispense as Written-DAW)*
Brand Name Drug	*$25 Copayment Amount* *(When no generic is available or Rx is prescribed Dispense as Written-DAW)*
Generic Drug	*Lesser of $7 Copayment Amount* *OR* *Actual Cost*

Note: Members electing to purchase brand name drugs when "Dispense as Written" (DAW) is not indicated will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name Copayment.

Specialty and biotech medications are available only through mail order unless purchased and administered through the doctor's office.

Mail Service Pharmacy-up to a 90-day supply	
Non-Preferred Brand Name Drug	*$80 Copayment Amount*
Brand Name Drug	*$50 Copayment Amount*
Generic Drug	*$14 Copayment Amount*

Note: Prescription Drug Benefits are provided by CVS Caremark through a master contract with the Texas Association of Counties Health and Employee Benefits Pool. Prescription Drugs are not administered by Blue Cross and Blue Shield of Texas

Initials _____ Date _____

For more information about your prescription drug benefits please refer to the **Prescription Drug Benefits** section in the back of this benefit booklet.

The Texas Association of Counties Health and Employee Benefits Pool (TAC HEBP) believes the Webb County Health Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to TAC HEBP at 1-800-456-5974. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

TABLE OF CONTENTS

Page No.

Schedule(s) of Coverage(s) . . . . . Enclosure

Introduction
Managed Health Care – In–Network Benefits 1
Managed Health Care – Out–of–Network Benefits 1
Important Contact Information 2
Customer Service Helpline 2
BCBSTX Website 2
Mental Health/Chemical Dependency Preauthorization Helpline 2
Medical Preauthorization Helpline 3

Who Gets Benefits
Eligibility Requirements for Coverage 4
Effective Dates of Coverage 4
Group Enrollment Application/Change Form 7
Changes In Your Family 7

How the Plan Works
Allowable Amount 8
Case Management 8
Freedom of Choice 8
Identification Card 9
Medical Necessity 9
ParPlan 9
Preexisting Conditions Provision 10
Specialty Care Providers 10
Use of Non–Contracting Providers 11

Preauthorization Requirements
Preauthorization Requirements 12
Failure to Preauthorize 14

Claim Filing and Appeals Procedures
Claim Filing Procedures 15
Filing of Claims Required 15
Who Files Claims 15
Where to Mail Completed Medical Claim Forms 15
Who Receives Payment 16
When to Submit Claims 16
Receipt of Claims by the Claims Administrator 16
Review of Claim Determinations 16
Claim Determinations 16
Preauthorization Appeal Procedures 17
Interpretation of Employer's Plan Provisions 18

Eligible Expenses, Payment Obligations, and Benefits
Eligible Expenses 19
Copayment Amounts 19
Deductibles 19
Co–Share Stop–Loss Amount 20
Changes In Benefits 20

Covered Medical Services
Inpatient Hospital Expenses 21
Medical–Surgical Expenses 21
Extended Care Expenses 22
Special Provisions Expenses 23
- Benefits for Treatment of Complications of Pregnancy 24
- Benefits for Maternity Care 24
- Benefits for Emergency Care and Treatment of Accidental Injury 24
- Benefits for Preventive Care 24
- Benefits for Mammography Screening 25

Benefits for Detection and Prevention of Osteoporosis 25
Benefits for Tests for Detection of Colorectal Cancer 25
Benefits for Certain Tests for Detection of Human Papillomavirus and Cervical Cancer 25
Benefits for Certain Tests for Detection of Prostate Cancer 26
Benefits for Speech and Hearing Services 26
Benefits for Childhood Immunizations 26
Benefits for Certain Therapies for Children with Developmental Delays 26
Benefits for Autism Spectrum Disorder 27
Benefits for Screening Tests for Hearing Impairment 27
Benefits for Cosmetic, Reconstructive, or Plastic Surgery 27
Benefits for Dental Services 28
Benefits for Organ and Tissue Transplants 28
Benefits for Treatment of Acquired Brain Injury 29
Benefits for Treatment of Diabetes 29
Benefits for Physical Medicine Services 31
Benefits for Chiropractic Services 31
Behavioral Health Services
Benefits for Treatment of Serious Mental Illness 31
Benefits for Mental Health Care and Treatment of Chemical Dependency 31

Medical Limitations and Exclusions 33

Definitions 37

General Provisions
Agent 51
Amendments 51
Assignment and Payment of Benefits 51
Claims Liability 51
Disclosure Authorization 51
Medicare 51
Participant/Provider Relationship 51
Refund of Benefit Payments 52
Subrogation 52
Coordination of Benefits 52
Termination of Coverage 55
Continuation of Group Coverage – Federal 56

Amendments

Notices

INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan. In the event of any conflict between any components of this Plan, the Administrative Services Agreement provided to your Employer by Blue Cross and Blue Shield of Texas (BCBSTX) prevails.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the **DEFINITIONS** section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms "you" and "your" as used in this Benefit Booklet refer to the Employee. Use of the masculine pronoun "his," "he," or "him" will be considered to include the feminine unless the context clearly indicates otherwise.

Managed Health Care – In–Network Benefits

To receive In–Network Benefits as indicated on your Schedule of Coverage, **you must** choose Providers within the Network for all care **(other than for emergencies)**. The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually. You may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

To receive In–Network Benefits for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency all care should be preauthorized by calling the toll–free Mental Health Helpline indicated on your Identification Card and in this Benefit Booklet. Services and supplies for Mental Health Care, Serious Mental Illness, and treatment of Chemical Dependency must be provided by Network Providers that have specifically contracted with the Claims Administrator to furnish services and supplies for those types of conditions to be considered for In–Network Benefits.

If you choose a Network Provider, the Provider will bill the Claims Administrator – not you – for services provided.

The Provider has agreed to accept as payment in full the least of...

- The billed charges, or
- The Allowable Amount as determined by the Claims Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Co–Share Amounts. You may be required to pay for limited or non–covered services. No claim forms are required.

Managed Health Care – Out–of–Network Benefits

If you choose Out–of–Network Providers, only Out–of–Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out–of–Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying…

- Billed charges above the Allowable Amount as determined by the Claims Administrator,
- Co−Share Amounts and Deductibles,
- Limited or non−covered services, and
- Failure to preauthorize penalty.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	**1−800−521−2227**	**Monday – Friday 8:00 a.m. – 8:00 p.m.**
Blue Cross Blue Shield of Texas Website	**www.bcbstx.com**	**24 hours a day 7 days a week**
Medical Preauthorization Helpline	**1−800−441−9188**	**Monday – Friday 7:30 a.m. – 6:00 p.m.**
Mental Health Helpline/Chemical Dependency Preauthorization Helpline	**1−800−528−7264**	**24 hours a day 7 days a week**
Texas Association of Counties Health and Employee Benefits Pool Website	**https://mybenefits.county.org**	**24 hours a day 7 days a week**

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and *ParPlan* Providers
- Distribute claim forms
- Answer your questions on claims
- Order replacement or additional Identification Cards
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and much more.

Mental Health/Chemical Dependency Preauthorization Helpline

To satisfy Preauthorization requirements for Participants seeking treatment for Behaviorial Health Services for Mental Health Care, Serious Mental Illness, and Chemical Dependency, you, your Behaviorial Health Practitioner,

or a family member may call the Mental Health/Chemical Dependency Preauthorization Helpline at any time, day or night.

Medical Preauthorization Helpline

To satisfy all medical Preauthorization requirements for inpatient Hospital Admissions, Extended Care Expenses, or Home Infusion Therapy, call the Medical Preauthorization Helpline.

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee or a Dependent and is in a class eligible to be covered under the Plan. The Eligibility Date is:

1. The date the Employee, including any Dependents to be covered, completes the Waiting Period, if any, for coverage;

2. Described in the ***Dependent Enrollment Period*** section for a new Dependent of an Employee already having coverage under the Plan.

Employee Eligibility

Any person eligible under this Plan and covered by the Employer's previous Health Benefit Plan on the date prior to the Plan Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Plan Effective Date. Otherwise, you are eligible for coverage under the Plan when you satisfy the definition of an Employee and you reside or work in the Plan Service Area.

Dependent Eligibility

If you apply for coverage, you may include your Dependents. Subject to the terms of this section, eligible Dependents are:

1. Your spouse;
2. A child under age 26;
3. A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
4. Any other child included as an eligible Dependent under the Plan.

A detailed description of Dependent is in the **DEFINITIONS** section of this Benefit Booklet. An Employee must be covered first in order to cover his eligible Dependents. No Dependent shall be covered hereunder prior to the Employee's Effective Date. If you are married to another Employee, you may not cover your spouse as a Dependent, and only one of you may cover any Dependent children.

All dependent spouses applying for coverage with the Texas Association of Counties Health and Employee Benefits Pool (TAC HEBP) January 1, 2007 or later, who are eligible for employer−sponsored group health coverage at their Employer, must first enroll in their employer−sponsored plan and provide proof of coverage, in order to be eligible to enroll in the TAC HEBP plan as a Dependent. Should the spouse's employer−sponsored group coverage situation be misrepresented, the Employee and their Dependents could lose eligibility for coverage with TAC HEBP.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment for coverage for himself and any Dependents. The Effective Date is the date the coverage for a Participant actually begins. The Effective Date under the Plan is shown on your Identification Card. It may be different from the Eligibility Date.

Timely Applications

It is important that your application for coverage under the Plan is received timely by the Claims Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions for yourself or for yourself and your eligible Dependents and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claims Administrator through the Plan Administrator prior to or within 31 days following such date, your coverage will become effective on the Plan Effective Date;

2. Enroll for coverage for yourself or for yourself and your Dependents during an Open Enrollment Period, coverage shall become effective on the Plan Anniversary Date; or

3. Become eligible after the Plan Effective Date and if the application is received by the Claims Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective in accordance with eligibility information provided by your Employer.

Effective Dates – Delay of Benefits Provided

Coverage becomes effective for you and/or your Dependents on the Plan Effective Date upon completion of an application for coverage. If you or your eligible Dependent(s) are confined in a Hospital or Facility Other Provider on the Plan Effective Date, your coverage is effective on the Plan Effective Date. However, if this Plan is replacing a discontinued Health Benefit Plan or self–funded Health Benefit Plan, benefits for any Employee or Dependent may be delayed until the expiration of any applicable extension of benefits provided by the previous Health Benefit Plan or self–funded Health Benefit Plan.

Effective Dates – Late Enrollee

If your application is not received within 31 days from the Eligibility Date, you will be considered a Late Enrollee. You will become eligible to apply for coverage during your Employer's next Open Enrollment Period. Your coverage will become effective on the Plan Anniversary Date. If you are a Late Enrollee, you may be subject to a 12–month Preexisting Condition limitation beginning on the Plan Anniversary Date.

Loss of Other Health Insurance Coverage

An Employee who is eligible, but not enrolled for coverage under the terms of the Plan (and/or a Dependent, if the Dependent is eligible, but not enrolled for coverage under such terms) shall become eligible to apply for coverage if each of the following conditions is met:

1. The Employee or Dependent was covered under a Health Benefit Plan, self–funded Health Benefit Plan, or had other health insurance coverage at the time this coverage was previously offered; and
2. Coverage was declined under this Plan in writing, on the basis of coverage under another Health Benefit Plan or self–funded Health Benefit Plan; and
3. There is a loss of coverage under such prior Health Benefit Plan or self–funded Health Benefit Plan as a result of:
   a. Exhaustion of continuation under Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended; or
   b. Cessation of Dependent status (such as divorce or attaining the maximum age to be eligible as a dependent child under the Plan), termination of employment, a reduction in the number of hours of employment, or employer contributions toward such coverage were terminated; or
   c. Termination of the other plan's coverage, a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits, a situation in which the other plan no longer offers any benefits to the class of similarly situated individuals that include you or your Dependent, or, in the case of coverage offered through an HMO, you or your Dependent no longer reside, live, or work in the service area of that HMO and no other benefit option is available; and
4. You request to enroll no later than 31 days after the date coverage ends under the prior Health Benefit Plan or self–funded Health Benefit Plan or, in the event of the attainment of a lifetime limit on all benefits, the request to enroll is made not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits. Coverage will become effective following the last day the Employee or Dependent held coverage under the prior Plan.

If all conditions described above are not met, you will be considered a Late Enrollee.

Loss of Governmental Coverage

An individual who is eligible to enroll and who has lost coverage under Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) or

under the Texas Children's Health Insurance Program (CHIP), Chapter 62, Health and Safety Code, is not a Late Enrollee provided appropriate enrollment application/change forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date on which such individual loses coverage. Coverage will be effective the day after prior coverage terminated.

Health Insurance Premium Payment (HIPP) Reimbursement Program

An individual who is eligible to enroll and who is a recipient of medical assistance under the state of Texas Medicaid Program or enrolled in CHIP, and who is a participant in the state of Texas HIPP Reimbursement Program may enroll with no enrollment period restrictions. If the individual is not eligible unless a family member is enrolled, both the individual and family member may enroll. The Effective Date of Coverage is on the first day of the month after the Claims Administrator receives (i) written notice from the Texas Health and Human Services Commission, or (ii) enrollment forms, from you, provided such forms and applicable contributions are received by the Claims Administrator within sixty (60) days after the date the individual becomes eligible for participation in the HIPP Reimbursement Program.

Dependent Enrollment Period

1. ***Special Enrollment Period for Newborn Children***
   Coverage of a newborn child will be automatic for the first 31 days following the birth of your newborn child. For coverage to continue beyond this time, you must notify the Claims Administrator through the Plan Administrator within 31 days of birth and pay any required contributions within that 31–day period or a period consistent with the next billing cycle. Coverage will become effective on the date of birth. If the Claims Administrator is notified through the Plan Administrator after that 31–day period, the newborn child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

2. ***Special Enrollment Period for Adopted Children or Children Involved in a Suit for Adoption***
   Coverage of an adopted child or child involved in a suit for adoption will be automatic for the first 31 days following the adoption or date on which a suit for adoption is sought. For coverage to continue beyond this time, the Claims Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31–day period or a period consistent with the next billing cycle. Coverage will become effective on the date of adoption or date on which a suit for adoption is sought. If you notify the Claims Administrator through the Plan Administrator after that 31–day period, the child's coverage will become effective on the Plan Anniversary Date following the Employer's next Open Enrollment Period.

3. ***Court Ordered Dependent Children***
   If a court has ordered an Employee to provide coverage for a child, coverage will be automatic for the first 31 days after the date your Employer receives notification of the court order. To continue coverage beyond the 31 days, the Claims Administrator through the Plan Administrator must receive all necessary forms and the required contributions within the 31–day period. If you notify the Claims Administrator through the Plan Administrator after that 31–day period, the Dependent child's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

4. ***Other Dependents***
   Written application must be received within 31 days of the date that a spouse or child first qualifies as a Dependent. If the written application is received within 31 days, coverage will become effective on the date the child or spouse first becomes an eligible Dependent. If application is not made within the initial 31 days, then your Dependent's coverage will become effective on the Plan Anniversary Date following your Employer's next Open Enrollment Period.

   If you ask that your Dependent be provided health care coverage after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions of the Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

Other Employee Enrollment Period

1. As a special enrollment period event, if you acquire a Dependent through birth, adoption, or through suit for adoption, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, as described above, you may apply for coverage for yourself, your spouse, and a newborn child, adopted child, or child involved in a suit for adoption. If the written application is received within 31 days of the birth, adoption, or suit for adoption, coverage for the child, you, or your spouse will become effective on the date of the birth, adoption, or date suit for adoption is sought.

   If you marry and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage*** as described above, you may apply for coverage for yourself and your spouse. If the written application is received within 31 days of the marriage, coverage for you and your spouse will become effective on the first day of the month following receipt of the application by the Claims Administrator through the Plan Administrator.

2. If you are required to provide coverage for a child as described in ***Court Ordered Dependent Children*** above, and you previously declined coverage for reasons other than under ***Loss of Other Health Insurance Coverage***, you may apply for coverage for yourself. If the written application is received within 31 days of the date your Employer receives notification of the court order, coverage for you will become effective on the date your Employer receives notification of the court order.

Group Enrollment Application/Change Form

Use this form to...

- Notify the Plan of a change to your name
- Add Dependents
- Drop Dependents
- Cancel all or a portion of your coverage
- Notify the Plan of all changes in address for yourself and your Dependents. An address change may result in benefit changes for you and your Dependents if you move out of the Plan Service Area of the Network.

You may obtain this form from your Employer, or by calling the Claims Administrator's Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSTX website. If a Dependent's address and zip code are different from yours, be sure to indicate this information on the form. After you have completed the form, return it to your Employer.

Changes In Your Family

You should promptly notify the Claims Administrator through the Plan Administrator in the event of a birth or follow the instructions below when events, such as but not limited to, the following take place:

- If you are adding a Dependent due to marriage, adoption, or a child being involved in a suit for which an adoption of the child is sought, or your Employer receives a court order to provide health coverage for a Participant's child or your spouse, you must submit a *Group Enrollment Application/Change Form* and the coverage of the Dependent will become effective as described in ***Dependent Enrollment Period***.

- When you divorce, your child reaches the age indicated on your Schedule of Coverage as "Dependent Child Age Limit," or a Participant in your family dies, coverage under the Plan terminates in accordance with the **Termination of Coverage** provisions selected by your Employer.

  Notify your Employer promptly if any of these events occur. Benefits for expenses incurred after termination are not available. If your Dependent's coverage is terminated, refund of contributions will not be made for any period before the date of notification. If benefits are paid prior to notification to the Claims Administrator by the Plan Administrator, refunds will be requested.

  Please refer to the **Continuation Privilege** subsection in this Benefit Booklet for additional information.

HOW THE PLAN WORKS

Allowable Amount

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

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

Case Management

Under certain circumstances, the Plan allows the Claims Administrator the flexibility to offer benefits for expenses which are not otherwise Eligible Expenses. The Claims Administrator, at its sole discretion, may offer such benefits if:

- The Participant, his family, and the Physician agree;
- Benefits are cost effective; and
- The Claims Administrator anticipates future expenditures for Eligible Expenses which may be reduced by such benefits.

Any decision by the Claims Administrator to provide such benefits shall be made on a case–by–case basis. The case coordinator for the Claims Administrator will initiate case management in appropriate situations.

Freedom of Choice

Each time you need medical care, you can choose to:		
See a Network Provider	***See an Out–of–Network Provider***	
	***ParPlan* Provider** *(refer to **ParPlan**, below, for more information)*	**Out–of–Network Provider** **(***not a contracting Provider***)**
• You receive the higher level of benefits (In–Network Benefits) • You are not required to file claim forms • You are not balance billed; Network Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • Your Provider will preauthorize necessary services	• You receive the lower level of benefits (Out–of–Network Benefits) • You are not required to file claim forms in most cases; *ParPlan* Providers will usually file claims for you • You are not balance billed; *ParPlan* Providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services • In most cases, *ParPlan* Providers will preauthorize necessary services	• You receive Out–of–Network Benefits (the lower level of benefits) • You are required to file your own claim forms • You may be billed for charges exceeding the Claims Administrator's Allowable Amount for covered services • You must preauthorize necessary services

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's Health Benefit Plan. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- ***Your Subscriber identification number***. This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claims Administrator.
- ***Your group number***. This is the number assigned to identify your Employer's Health Benefit Plan with the Claims Administrator.
- ***Any Copayment Amounts that may apply to your coverage.***
- ***Important telephone numbers***.

Always remember to carry your Identification Card with you and present it to your Providers when receiving health care services or supplies.

Please remember that any time a change in your family takes place it may be necessary for a new Identification Card to be issued to you (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, the Claims Administrator will provide a new Identification Card.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:

   a. Use of the Identification Card prior to your Effective Date;
   b. Use of the Identification Card after your date of termination of coverage under the Plan;
   c. Obtaining other benefits for persons not covered under the Plan;
   d. Obtaining other benefits that are not covered under the Plan;

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

   a. Denial of benefits;
   b. Cancellation of coverage under the Plan for **all** Participants under your coverage;
   c. Limitation on the use of the Identification Card to one designated Physician, Other Provider of your choice;
   d. Recoupment from you or any of your covered Dependents of any benefit payments made;
   e. Pre–approval of medical services for all Participants receiving benefits under your coverage;
   f. Notice to proper authorities of potential violations of law or professional ethics.

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claims Administrator. Charges for services and supplies which the Claims Administrator determines are not Medically Necessary will not be eligible for benefit consideration and may not be used to satisfy Deductibles or to apply to the Co–Share Stop–Loss Amount.

ParPlan

When you consult a Physician or Professional Other Provider who does not participate in the Network, you should inquire if he participates in the Claims Administrator's *ParPlan*…a simple direct–payment arrangement. If the Physician or Professional Other Provider participates in the *ParPlan,* he agrees to:

- File all claims for you,
- Accept the Claim Administrator's Allowable Amount determination as payment for Medically Necessary services, and
- Not bill you for services over the Allowable Amount determination.

You will receive Out–of–Network Benefits and be responsible for:

- Any Deductibles,
- Co–Share Amounts, and
- Services that are limited or not covered under the Plan.

NOTE: If you have a question regarding a Physician's or Professional Other Provider's participation in the *ParPlan*, please contact the Claims Administrator's Customer Service Helpline.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the 12–month period following the Participant's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period, (typically the date you are hired).

The Preexisting Condition exclusion **will not apply** to:

1. Any individual under age 19; or

2. A newborn child who is added as described in ***Dependent Enrollment Period*** within the first 31 days after the date of birth; or

3. A child who is adopted or involved in a suit for adoption before attaining the limiting age shown in the Schedule of Coverage and who applies, as described in ***Dependent Enrollment Period***, for coverage under this Plan; or

4. A court ordered Dependent of a covered Employee who applies for coverage as described in ***Dependent Enrollment Period***; or

5. An individual who was continuously covered for an aggregate period of twelve months under Creditable Coverage that was in effect up to a date not more than 63 days before the Effective Date of coverage under the Health Benefit Plan, excluding any Waiting Periods.

The Claim Administrator will credit the time you were covered under Creditable Coverage if the previous coverage was in effect under a Health Benefit Plan or self–funded Health Benefit Plan at any time during the twelve months prior to the Effective Date of coverage under this Plan. If the previous coverage was issued under a Health Benefit Plan, any waiting period that applied before that coverage became effective also will be credited against the Preexisting Condition exclusion.

Pregnancy, conditions resulting from domestic violence, and genetic information without a diagnosis of a specific condition shall not be considered a Preexisting Condition.

All other terms, provisions, limitations, and exclusions will apply to all Participants even if any Preexisting Condition exclusion is not applicable for the reasons set out above.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In–Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out–of–Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network Providers, In–Network Benefits will be provided when you use Out–of–Network Providers.

- If you elect to see an Out−of−Network Provider and if the services could have been provided by a Network Provider, only Out−of−Network Benefits will be available.

Use of Non−Contracting Providers

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

PREAUTHORIZATION REQUIREMENTS

Preauthorization Requirements

Preauthorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the Preauthorized care and services described below will not be denied on the basis of Medical Necessity or Experimental/Investigational. However, Preauthorization does not guarantee payment of benefits.

Coverage is always subject to other requirements of the Plan, such as Preexisting Conditions, limitations and exclusions, payment of contributions, and eligibility at the time care and services are provided.

The following types of services require Preauthorization:

- All inpatient Hospital Admissions,
- Extended Care Expenses,
- Home Infusion Therapy,
- All inpatient and outpatient treatment of Chemical Dependency,
- All inpatient and outpatient treatment of Mental Health Care,
- All inpatient and outpatient treatment of Serious Mental Illness, and
- If you transfer to another facility or to or from a specialty unit within the facility.

In–Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. In–Network Providers will preauthorize services for you, when required.

If you elect to use Out–of–Network Providers for services and supplies available In–Network, Out–of–Network Benefits will be paid.

However, if care is not available from Network Providers as determined by the Claim Administrator, and the Claim Administrator acknowledges your visit to an Out–of–Network Provider **prior to the visit**, In–Network Benefits will be paid; otherwise, Out–of Network Benefits will be paid and the claim will have to be resubmitted for review and adjusted, if appropriate.

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

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

To satisfy Preauthorization requirements, on business days between 7:30 a.m. and 6:00 p.m. Central Time, you, your Physician, Provider of services, or a family member should call one of the Customer Service toll–free numbers listed on the back of your Identification Card. After working hours or on weekends, please call the **Medical Preauthorization Helpline** toll–free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Preauthorization requirements are provided in keeping with applicable state and federal regulations.

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

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

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

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

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

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

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

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

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

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

Preauthorization for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency
In order to receive maximum benefits, all inpatient treatment and outpatient treatment for Mental Health Care, Serious Mental Illness, and Chemical Dependency must be Preauthorized.

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

In−Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out−of−Network Providers for services and supplies available In−Network, Out−of−Network Benefits will be

paid. In−Network and Out−of−Network Providers may Preauthorize services for you, when required, but it is your responsibility to ensure Preauthorization requirements are satisfied.

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

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

Failure to Preauthorize

If Preauthorization for inpatient Hospital Admissions, Extended Care Expense, Home Infusion Therapy, all inpatient and outpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency is not obtained:

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

  The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

If an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Chemical Dependency or extension for any treatment or service described above is not Preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or Experimental/Investigational, benefits will be reduced or denied.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

Claim Forms

When the Claims Administrator receives notice of claim, it will furnish to you, or to your Employer for delivery to you, the Hospital, or your Physician or Professional Other Provider, the claim forms that are usually furnished by it for filing Proof of Loss.

The Claims Administrator for the Plan must receive claims prepared and submitted in the proper manner and form, in the time required, and with the information requested before it can consider any claim for payment of benefits.

Who Files Claims

Providers that contract with the Claims Administrator and some other health care Providers (such as *ParPlan* Providers) will submit your claims directly to the Claims Administrator for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Providers in filing your claims, you should carry your Identification Card with you.

Contracting Providers

When you receive treatment or care from a Provider that contracts with the Claims Administrator, you will generally not be required to file claim forms. The Provider will usually submit the claims directly to the Claims Administrator for you.

Non−Contracting Providers

When you receive treatment or care from a health care Provider that does not contract with the Claims Administrator, you may be required to file your own claim forms. Some Providers, however, will do this for you. If the Provider does not submit claims for you, refer to the subsection entitled ***Participant−filed claims*** below for instruction on how to file your own claim forms.

Participant−filed Medical claims

If your Provider does not submit your claims, you will need to submit them to the Claims Administrator using a Subscriber−filed claim form provided by the Plan. Your Employer should have a supply of claim forms or you can obtain copies from the BCBSTX website. Follow the instructions on the reverse side of the form to complete the claim. Remember to file each Participant's expenses separately because any Copayment Amounts, Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the health care Providers, labs, etc., printed on their letterhead and showing the services performed, dates of service, charges, and name of the Participant involved.

VISIT THE BCBSTX WEBSITE FOR SUBSCRIBER CLAIM FORMS AND OTHER USEFUL INFORMATION
www.bcbstx.com

Where to Mail Completed Medical Claim Forms

Blue Cross and Blue Shield of Texas
Claims Division
P. O. Box 660044
Dallas, Texas 75266−0044

Who Receives Payment

Benefit payments will be made directly to contracting Providers when they bill the Claims Administrator. Written agreements between the Claims Administrator and some Providers may require payment directly to them.

Any benefits payable to you, if unpaid at your death, will be paid to your surviving spouse, as beneficiary. If there is no surviving spouse, then the benefits will be paid to your estate.

Except as provided in the section **Assignment and Payment of Benefits,** rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claims Administrator has not already paid any portion of the claim.

In order for benefits to be payable to a managing or possessory conservator of a child, the managing or possessory conservator must submit to the Claims Administrator, with the claim form, proof of payment of the expenses and a certified copy of the court order naming that person the managing or possessory conservator.

The Claims Administrator for the Health Benefit Plan may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Provider, or deduction by the Plan from benefit payments of amounts owed to it, will be considered in satisfaction of its obligations to you under the Plan.

An *Explanation of Benefits* summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Health Benefit Plan must be properly submitted to the Claims Administrator within twelve (12) months of the date you receive the services or supplies. Claims submitted and received by the Claims Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claims Administrator

A claim will be considered received by the Claims Administrator for processing upon actual delivery to the Administrative Office of the Claims Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it may be denied or the Claims Administrator may contact either you or the Provider for the additional information.

After processing the claim, the Claims Administrator will notify the Participant by way of an *Explanation of Benefits* summary.

REVIEW OF CLAIM DETERMINATIONS

Claim Determinations

When the Claims Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Health Benefit Plan provisions. The Claims Administrator will receive and review claims for benefits and will accurately process claims consistent with administrative practices and procedures established in writing between the Claims Administrator and the Plan Administrator. The Claims Administrator will render an initial decision to pay or deny a claim within 30 days of receipt of the claim. If the Claims Administrator requires further information in order to process the claim, the Claims Administrator will request it within that 30−day period.

You have the right to seek and obtain a full and fair review by the Claims Administrator of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claims Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the *Explanation of Benefits* summary prepared by the Claims Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision. Include your full name, group and subscriber numbers with the request.

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

- The reasons for denial;
- A reference to the Health Benefit Plan provisions on which the denial is based;
- A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
- An explanation of how you may have the claim reviewed by the Claims Administrator if you do not agree with the denial.

Right to Review Claim Determinations

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

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

- Within 180 days after you receive notice of a denial or partial denial, write to the Claims Administrator's Administrative Office. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claims Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Claims Administrator will give you a written decision within 60 days after it receives your request for review.
- If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator's Administrative Office or call the toll–free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

Preauthorization Appeal Procedures

If you or your Physician disagree with the determination of the Preauthorization prior to or while receiving services, you may appeal that decision by contacting the Claims Administrator's Administrative Office.

In some instances, the resolution of the appeal process will not be completed until your inpatient admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter from the Claims Administrator, you may request a review of that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

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

Once you have requested this review, you may submit additional information and comments on your Preauthorization decision to the Claims Administrator as long as you do so within 30 days of the date you ask for a review. Also, during this 30–day period, you may review any documents relevant to your Preauthorization decision held by the Claims Administrator.

Within 30 days of receiving your request to review, the Claims Administrator will send you its decision on the claim. In unusual situations, an additional 15 days may be needed for the review and you will be notified of this during the first 30–day period.

Interpretation of Employer's Plan Provisions

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non–discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the **Review of Claims Determinations** section prior to taking further action under your Health Benefit Plan.

After exhaustion of all remedies offered by the Claims Administrator, you may exercise your right to appeal all adverse determinations with the Plan Administrator of your Health Benefit Plan. The Plan Administrator is the final interpreter of the Health Benefit Plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable. All final determinations and actions concerning the Health Benefit Plan administration and interpretation of benefits shall be made by the Plan Administrator. The Claims Administrator will cooperate in providing the Plan Administrator documents relevant to the claim or Preauthorization decision upon receipt of a valid written authorization from you or your representative to release the relevant information.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS

Eligible Expenses

The Plan provides coverage for four categories of Eligible Expenses:

- Inpatient Hospital Expenses,
- Medical–Surgical Expenses,
- Extended Care Expenses, and
- Special Provisions Expenses

Wherever Schedule of Coverage is mentioned, please refer to your Schedule(s) in this Benefit Booklet. Your benefits are calculated on a Calendar Year benefit period basis unless otherwise stated. At the end of a Calendar Year, a new benefit period starts for each Participant.

Copayment Amounts

Some of the care and treatment you receive under the Plan will require that a Copayment Amount be paid at the time you receive the services. Refer to your Schedule of Coverage under "Copayment Amounts Required" for your specific Plan information.

A Copayment Amount will be required for most Physician office visits, including lab and x–ray. If the services provided by your Physician require a return office visit (lab services for instance) on a different day, a new Copayment Amount will be required. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits.

The following services are not payable under this Copayment Amount provision but instead are considered Medical–Surgical Expense and may be subject to any Deductible shown on your Schedule of Coverage:

- surgery performed in the Physician's office;
- physical therapy billed separately from an office visit;
- occupational modalities in conjunction with physical therapy;
- allergy injections billed separately from an office visit;
- therapeutic injections;
- any services requiring Preauthorization;
- Certain Diagnostic Procedures;
- services provided by an Independent Lab, Imaging Center, radiologist, pathologist, and anesthesiologist;
- outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis.

A Copayment Amount will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived.

Deductibles

The benefits of the Plan will be available after satisfaction of the applicable Deductibles as shown on your Schedule of Coverage. The Deductibles are explained as follows:

Calendar Year Deductible: The individual Deductible amount shown under "Deductibles" on your Schedule of Coverage must be satisfied by each Participant under your coverage each Calendar Year. This Deductible will be applied to all Medical–Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses (unless otherwise indicated) before benefits are available under the Plan.

The following are exceptions to the Deductibles described above:

Your Schedule of Coverage indicates "Three–Month Deductible carryover applies." This means that any Eligible Expenses incurred during the last three months of a Calendar Year and applied toward satisfaction of the "Calendar Year Deductible" for that Calendar Year may be applied toward satisfaction of the Deductible for the following Calendar Year.

If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount shown on your Schedule of Coverage. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.

Eligible Expenses applied toward satisfying the "per individual" and "per family" Out–of–Network Deductible will apply toward both the Out–of–Network and the In–Network Deductible. However, Eligible Expenses applied toward satisfying the "per individual" and "per family" In–Network Deductible will not apply toward satisfying the Out–of–Network Deductible.

Co–Share Stop–Loss Amount

Most of your Eligible Expense payment obligations, including Copayment Amounts are considered Co–Share Amounts and are applied to the Co–Share Stop–Loss Amount maximum.

Your Co–Share Stop–Loss Amount will **not** include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when the Plan is the Secondary Plan for purposes of coordination of benefits;
- Any Deductibles;
- Penalties applied for failure to preauthorize.

Individual Co–Share Stop–Loss Amount

When the Co–Share Amount for the In–Network or Out–of–Network Benefits level for a Participant in a Calendar Year equals the "per individual" "Co–Share Stop–Loss Amount" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.

Family Co–Share Stop–Loss Amount

When the Co–Share Amount for the In–Network or Out–of–Network Benefits level for all Participants under your coverage in a Calendar Year equals the "per family" "Co–Share Stop–Loss Amount" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Co–Share Stop–Loss Amount to the family "Co–Share Stop–Loss Amount."

The following are exceptions to the Co–Share Stop–Loss Amounts described above:

There are separate Co–Share Stop–Loss Amounts for In–Network Benefits and Out–of–Network Benefits.

Eligible Expenses applied toward satisfying the "per individual" and "per family" Out–of–Network Co–Share Stop–Loss Amount maximum will apply toward both the In–Network and Out–of–Network Co–Share Stop–Loss Amount. However, Eligible Expenses applied toward satisfying the "per individual" and "per family" In–Network Co–Share Stop–Loss Amount maximum will not apply toward satisfying the Out–of–Network Co–Share Stop–Loss Maximum amount.

Copayment Amounts for In–Network Benefits and Out–of–Network Benefits will continue to be required after the benefit percentages become 100%.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

COVERED MEDICAL SERVICES

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses for you and your eligible Dependents. Each inpatient Hospital Admission requires Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for additional information.

The benefit percentage of your total eligible Inpatient Hospital Expense, in excess of any Deductible, shown under "Inpatient Hospital Expenses" on your Schedule of Coverage is the Plan's obligation. The remaining unpaid Inpatient Hospital Expense, in excess of any Deductible, is your obligation to pay. This excess amount will be applied to the Co–Share Amounts.

Services and supplies provided by an Out–of–Network Provider will receive In–Network Benefits when those services and supplies are not available from a Network Provider provided the Claims Administrator acknowledges your visit to an Out–of–Network Provider **prior** to the visit. Otherwise, Out–of–Network Benefits will be paid and the claim will have to be resubmitted for review and adjustment, if appropriate.

Refer to your Schedule of Coverage for information regarding Deductibles, Co–Share percentages, and penalties for failure to preauthorize that may apply to your coverage.

Medical–Surgical Expenses

The Plan provides coverage for Medical–Surgical Expense for you and your covered Dependents. Some services require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Copayment Amounts must be paid to your Network Physician or other Network Providers at the time you receive services.

The benefit percentages of your total eligible Medical–Surgical Expense shown under "Medical–Surgical Expenses" on your Schedule of Coverage in excess of your Copayment Amounts, Co–Share Amounts, and any applicable Deductibles shown are the Plan's obligation. The remaining unpaid Medical–Surgical Expense in excess of the Copayment Amounts, Co–Share Amounts, and any Deductibles is your obligation to pay.

Medical–Surgical Expense shall include:

1. Services of Physicians and Professional Other Providers. If services are received from a Licensed Professional Counselor, a professional recommendation should be obtained from the Physician.

2. Consultation services of a Physician and Professional Other Provider.

3. Services of a certified registered nurse–anesthetist (CRNA).

4. Diagnostic x–ray and laboratory procedures.

5. Radiation therapy.

6. Rental of durable medical equipment required for therapeutic use unless purchase of such equipment is required by the Plan. The term "durable medical equipment (DME)" shall not include:

    a. Equipment primarily designed for alleviation of pain or provision of patient comfort; or

    b. Home air fluidized bed therapy.

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

7. Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.

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

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

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

11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.

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

13. Home Infusion Therapy.

14. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.

15. Certain Diagnostic Procedures.

16. Outpatient Contraceptive Services.

17. Foot care in connection with an illness, disease, or condition, such as but not limited to peripheral neuropathy, chronic venous insufficiency, and diabetes.

18. Injectable drugs, administered by or under the direction or supervision of a Physician or Professional Other Provider.

19. Elective Sterilizations.

Extended Care Expenses

The Plan also provides benefits for Extended Care Expenses for you and your covered Dependents. All Extended Care Expenses require Preauthorization. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

The Plan's benefit obligation as shown on your Schedule of Coverage will be:

1. At the benefit percentage under "Extended Care Expenses," and

2. Up to the amount of the benefit maximums shown for each category of Extended Care Expenses on your Schedule of Coverage.

All payments made by the Plan, whether under the In−Network or Out−of−Network Benefit level, will apply toward the benefit maximums under both levels of benefits.

The benefit maximums will also include any benefits provided to a Participant for Extended Care Expenses under a Health Benefit Plan held by the Employer with the Claims Administrator immediately prior to the Participant's Effective Date of coverage under the Plan.

If shown on your Schedule of Coverage, the Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Co–Share Stop–Loss Amount.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical–Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:

   a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
   c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.

2. For Home Health Care:

   a. Part–time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Part–time or intermittent home health aide services which consist primarily of caring for the patient;
   c. Physical, occupational, speech, and respiratory therapy services by licensed therapists;
   d. Supplies and equipment routinely provided by the Home Health Agency.

   Benefits will **not** be provided for Home Health Care for the following:

   - Food or home delivered meals;
   - Social case work or homemaker services;
   - Services provided primarily for Custodial Care;
   - Transportation services;
   - Home Infusion Therapy;
   - Durable medical equipment.

3. For Hospice Care:

   Home Hospice Care:

   a. Part–time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Part–time or intermittent home health aide services which consist primarily of caring for the patient;
   c. Physical, speech, and respiratory therapy services by licensed therapists;
   d. Homemaker and counseling services routinely provided by the Hospice agency, including bereavement counseling.

   Facility Hospice Care:

   a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed Vocational Nurse (L.V.N.);
   b. Room and board and all routine services, supplies, and equipment provided by the Hospice facility;
   c. Physical, speech, and respiratory therapy services by licensed therapists.

Special Provisions Expenses

The benefits available under this **Special Provisions Expenses** subsection are generally determined on the same basis as other Inpatient Hospital Expenses, Medical–Surgical Expenses, and Extended Care Expenses, except to the

extent described in each item. Benefits for Medically Necessary expenses will be determined as indicated on your Schedule(s) of Coverage. Remember that certain services require Preauthorization and that any Copayment Amounts, Co−Share Amounts, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

Charges for well−baby nursery care, including the initial examination, of a newborn child during the mother's Hospital Admission for the delivery will be considered Inpatient Hospital Expense of the child and will be subject to the benefit provisions as described under **Inpatient Hospital Expenses**. Benefits will also be subject to any Deductible amounts shown on your Schedule of Coverage.

Benefits for Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room. He can help you determine if you need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether you require hospitalization or not, you should notify your Network Physician or Behavioral Health Practitioner within 48 hours, or as soon as reasonably possible, of any emergency medical treatment so he can recommend the continuation of any necessary medical services.

Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown on your Schedule of Coverage. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room visit as indicated on your Schedule of Coverage. If admitted for the emergency condition immediately following the visit, the Copayment Amount will be waived and Preauthorization of the inpatient Hospital Admission will be required.

All treatment received following the onset of an accidental injury or emergency care will be eligible for Network Benefits. For a non−emergency, Network Benefits will be available only if you use Network Providers. For a non−emergency, if you can safely be transferred to the care of a Network Provider but are treated by an Out−of−Network Provider, only Out−of−Network Benefits will be available.

Benefits for Preventive Care

Benefits for Medical−Surgical Expense are available for the following preventive care services as indicated on your Schedule of Coverage:

- well–baby care (after the newborn's initial examination and discharge from the Hospital);
- routine annual physical examination, including routine lab and x–ray;
- annual vision examination;
- annual hearing examinations, except for benefits as provided under ***Benefits for Screening Tests for Hearing Impairment***;
- immunizations for Participants age six and over.

Benefits for childhood immunizations will be provided as described in ***Benefits for Childhood Immunizations*** for children under the age of six. Benefits are not available for Inpatient Hospital Expense or Medical–Surgical Expenses for routine physical examinations performed on an inpatient basis, except for the initial examination of a newborn child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Mammography Screening

If a Participant 35 years of age and older incurs Medical–Surgical Expenses for a screening by low–dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other Medical–Surgical Expense as shown on your Schedule of Coverage, except that benefits will not be available for more than one routine mammography screening each Calendar Year.

Benefits for Detection and Prevention of Osteoporosis

If a Participant is a *Qualified Individual*, Medical–Surgical Expense benefits will be determined on the same basis as any other sickness for medically accepted bone mass measurement for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis.

Qualified Individual means:

a. A postmenopausal woman not receiving estrogen replacement therapy;

b. An individual with:

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

c. An individual who is:

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

Benefits for Tests for Detection of Colorectal Cancer

Benefits for Medical–Surgical Expenses incurred for a diagnostic, medically recognized screening examination for the detection of colorectal cancer, for Participants who are at normal risk for developing colon cancer, will be determined under Preventive Care as shown on your Schedule of Coverage for:

- A fecal occult blood; or
- A flexible sigmoidoscopy; or
- A colonoscopy.

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

Benefits will be determined on the same basis as for other Medical–Surgical Expenses as shown on your Schedule of Coverage, for each woman enrolled in the Plan who is 18 years of age or older, for Eligible Expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage includes, at a minimum, a conventional Pap smear screening or a screening using liquid–based cytology methods as approved by the United States Food and Drug Administration alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Benefits for Certain Tests for Detection of Prostate Cancer

If a male Participant incurs Medical−Surgical Expenses for diagnostic medical procedures incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer, benefits will be provided only for a:

a. physical examination for the detection of prostate cancer; and

b. prostate−specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:

   (1) 50 years of age and asymptomatic; or

   (2) 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Benefits for Speech and Hearing Services

Benefits as shown on your Schedule of Coverage are available for the services of a Physician or Professional Other Provider to restore loss of or correct an impaired speech or hearing function.

Benefits for Childhood Immunizations

Benefits for Medical−Surgical Expenses incurred by a Dependent child for childhood immunizations from birth through the date the child turns six years of age will be determined at 100% of the Allowable Amount. Deductibles, Copayment Amounts, and Co−Share Amounts will not be applicable.

Benefits are available for:

- Diphtheria,
- Hemophilus influenza type b,
- Hepatitis B,
- Measles,
- Mumps,
- Pertussis,
- Polio,
- Rubella,
- Tetanus,
- Varicella, and
- Any other immunization that is required by law for the child.

Injections for allergies are not considered immunizations under this benefit provision.

Benefits for Certain Therapies for Children with Developmental Delays

Medical−Surgical Expense benefits are available to a covered Dependent child for the necessary rehabilitative and habilitative therapies in accordance with an Individualized Family Service Plan.

Such therapies include:

- occupational therapy evaluations and services;
- physical therapy evaluations and services;
- speech therapy evaluations and services; and
- dietary or nutritional evaluations

The *Individualized Family Service Plan* must be submitted to the Claims Administrator prior to the commencement of services and when the Individualized Family Service Plan is altered.

Once the child reaches the age of 3, when services under the *Individualized Family Service Plan* are completed, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximums.

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

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

Individualized Family Service Plan means an initial and ongoing treatment plan.

Benefits for Autism Spectrum Disorder

Generally recognized services prescribed in relation to Autism Spectrum Disorder by the Participant's Physician or Behavioral Health Practitioner in a treatment plan recommended by that Physician or Behavioral Health Practitioner are available for a covered Dependent child from birth but who has not yet reached the age of ten.

Individuals providing treatment prescribed under that plan must be a health care practitioner:

- who is licensed, certified, or registered by an appropriate agency of the state;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a provider under the TRICARE military health system.

For purposes of this section, generally recognized services may include services such as:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; or
- medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

After the Dependent child reaches the age of ten, Eligible Expenses, as otherwise covered under this Plan, will be available. All contractual provisions of this Plan will apply, including but not limited to, defined terms, limitations and exclusions and Preauthorization.

Benefits for Screening Tests for Hearing Impairment

Benefits are available for Eligible Expenses incurred by a covered Dependent child:

- For a screening test for hearing loss from birth through the date the child is 30 days old; and
- Necessary diagnostic follow–up care related to the screening tests from birth through the date the child is 24 months.

Deductibles indicated on your Schedule of Coverage will not apply to this provision.

Benefits for Cosmetic, Reconstructive, or Plastic Surgery

The following Eligible Expenses described below for Cosmetic, Reconstructive, or Plastic Surgery will be the same as for treatment of any other sickness as shown on your Schedule of Coverage:

- Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant; or
- Treatment provided for reconstructive surgery following cancer surgery; or
- Surgery performed on a newborn child for the treatment or correction of a congenital defect; or

- Surgery performed on a covered Dependent child (other than a newborn child) under the age of 19 for the treatment or correction of a congenital defect other than conditions of the breast; or
- Reconstruction of the breast on which mastectomy has been performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; and prostheses and treatment of physical complications, including lymphedemas, at all stages of the mastectomy; or
- Reconstructive surgery performed on a covered Dependent child under the age of 19 due to craniofacial abnormalities to improve the function of, or attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Benefits for Dental Services

Benefits for Eligible Expenses incurred by a Participant will be provided on the same basis as for treatment of any other sickness as shown on your Schedule of Coverage only for the following:

- Covered Oral Surgery;
- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by external, violent Accidental Injury to healthy, un−restored natural teeth and supporting tissues and limited to treatment provided within 24 months of the initial treatment. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in **Benefits for Inpatient Hospital Expenses**.

Benefits for Organ and Tissue Transplants

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

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

   Covered services and supplies "related to" an organ or tissue transplant include, but are not limited to, x−rays, laboratory testing, chemotherapy, radiation therapy, procurement of organs or tissues from a living or deceased donor, and complications arising from such transplant.

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

   Benefits will be available for:

   (1) A recipient who is covered under this Plan; and
   (2) A donor.

c. Covered services and supplies include services and supplies provided for the:

   (1) Evaluation of organs or tissues including, but not limited to, the determination of tissue matches; and
   (2) Removal of organs or tissues from living or deceased donors; and

(3) Transportation and short−term storage of donated organs or tissues.

d. No benefits are available for a Participant for the following services or supplies:

(1) Donor search and acceptability testing of potential live donors;
(2) Living and/or travel expenses of the recipient or a live donor;
(3) Expenses related to maintenance of life of a donor for purposes of organ or tissue donation;
(4) Purchase of the organ or tissue; or
(5) Organs or tissue (xenograft) obtained from another species.

e. Preauthorization is required for any organ or tissue transplant. Review the **PREAUTHORIZATION REQUIREMENTS** subsection in this Benefit Booklet for more specific information about Preauthorization.

(1) Such specific Preauthorization is required even if the patient is already a patient in a Hospital under another Preauthorization authorization.
(2) At the time of Preauthorization, the Claims Administrator will assign a length−of−stay for the admission. Upon request, the length−of−stay may be extended if the Claims Administrator determines that an extension is Medically Necessary.

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

Benefits for Treatment of Acquired Brain Injury

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

- Neurobehavioral testing − An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre−morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment − Interventions that focus on behavior and the variables that control behavior;
- Neurophysiological testing − An evaluation of the functions of the nervous system;
- Neurophysiological treatment − Interventions that focus on the functions of the nervous system;
- Neuropsychological testing − The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment − Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Psychophysiological testing − An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment − Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation − The process(es) of restoring or improving a specific function.

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

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

Benefits for Treatment of Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for *Diabetes Equipment* and *Diabetes Supplies* (for which a Physician or Professional Other Provider has

written an order) and *Diabetic Management Services/Diabetes Self−Management Training*. Such items, when obtained for a *Qualified Participant,* shall include but not be limited to the following:

a. *Diabetes Equipment*

(1) Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);

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

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

(3) Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

b. *Diabetes Supplies*

(1) Test strips specified for use with a corresponding blood glucose monitor,

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

(3) Lancets and lancet devices,

(4) Insulin and insulin analog preparations,

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

(6) Biohazard disposable containers,

(7) Insulin syringes,

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

(9) Glucagon emergency kits.

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

d. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

e. Medical−Surgical Expense provided for the nutritional, educational, and psychosocial treatment of the *Qualified Participant*. Such *Diabetic Management Services/Diabetes Self−Management Training* for which a Physician or Professional Other Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.

Initial and follow−up instruction concerning:

(1) The physical cause and process of diabetes;

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

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

(4) Adjustment to lifestyle modifications; and

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

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

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

Benefits for Physical Medicine Services

Benefits for Medical−Surgical Expenses incurred for Physical Medicine Services are available and will be determined on the same basis as treatment for any other sickness shown on your Schedule of Coverage.

Benefits for Chiropractic Services

Benefits for Medical−Surgical Expenses incurred for Chiropractic Services are available as shown on your Schedule of Coverage.

However, Chiropractic Services benefits for all visits during which physical treatment is rendered, whether under the In−Network or Out−of−Network Benefits level, will not be provided for more than the maximum number of visits (outpatient facility and office combined) shown on your Schedule of Coverage. Any visits during which no physical treatment is rendered will not count toward the visit maximum.

Behavioral Health Services

Benefits for Treatment of Serious Mental Illness

Benefits for Eligible Expenses incurred for the treatment of Serious Mental Illness are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

Medically Necessary services for the treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan and any Deductible as shown on your Schedule of Coverage will apply.

Benefits for Mental Health Care and Treatment of Chemical Dependency

Benefits for Eligible Expenses incurred for the treatment of Mental Health Care and treatment of Chemical Dependency are shown on your Schedule of Coverage. Refer to the **PREAUTHORIZATION REQUIREMENTS** subsection to determine what services require Preauthorization.

Mental Health Care provided as part of the Medically Necessary treatment of Chemical Dependency will be considered for benefit purposes to be treatment of Chemical Dependency until completion of the series of Chemical Dependency treatments. (Mental Health Care treatment after completion of a series of Chemical Dependency treatments will be considered Mental Health Care.)

Coverage for treatment of Chemical Dependency will be limited to a maximum of three separate series of treatments per lifetime for each covered individual. Inpatient treatment of Chemical Dependency must be provided in a Chemical Dependency Treatment Center. Benefits for the medical management of acute life−threatening intoxication (toxicity) in a Hospital will be available on the same basis as for sickness generally as described under **Benefits for Inpatient Hospital Expense**.

Inpatient Hospital Expenses for Mental Health Care and treatment of Chemical Dependency will be limited to the number of inpatient days per Calendar Year shown on your Schedule of Coverage.

Medical−Surgical Expenses incurred for Mental Health Care and treatment of Chemical Dependency will be limited to the number of inpatient Physician, Behavioral Health Practitioner and/or Professional Other Provider visits per Calendar Year shown on your Schedule of Coverage.

Benefits for Medical−Surgical Expense incurred for Mental Health Care and treatment of Chemical Dependency will be limited to the combined number of outpatient Physician, Behavioral Health Practitioner and/or Professional Other Provider or other outpatient visits per Calendar Year shown on your Schedule of Coverage.

Medically Necessary treatment of Chemical Dependency and/or Mental Health Care in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered Inpatient Hospital Expense. The Inpatient Hospital Expense benefit percentages for this Plan and any Deductible as shown on your Schedule of Coverage will apply. Each full day of treatment in such facility will be considered equal to one−half of one day of a regular Hospital Admission for Mental Health Care.

All inpatient benefits used, including Hospital days and Physician/Behavioral Health Practitioner/Professional Other Provider visits, whether In−Network or Out−of−Network, apply to inpatient days or visits shown on your Schedule of Coverage under each level of benefits.

All outpatient Physician, Behavioral Health Practitioner and/or Professional Other Provider and other outpatient visit benefits used, whether In−Network or Out−of−Network, apply to outpatient visits shown on your Schedule of Coverage under each level of benefits.

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.

2. Any Experimental/Investigational services and supplies.

3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claims Administrator.

4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.

5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations or established procedures of any county or municipality, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical–surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

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

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

8. Any services or supplies provided for injuries sustained:

   - As a result of war, declared or undeclared, or any act of war; or
   - While on active or reserve duty in the armed forces of any country or international authority.

9. Any charges:

   - Resulting from the failure to keep a scheduled visit with a Physician or Professional Other Provider; or
   - For completion of any insurance forms; or
   - For acquisition of medical records.

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

11. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.

12. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:

    - an inpatient nutritional assessment program provided in and by a Hospital and approved by the Claims Administrator;
    - ***Benefits for Treatment of Diabetes*** as described in **Special Provisions Expenses**; or;
    - ***Benefits for Certain Therapies for Children with Developmental Delays*** as described in **Special Provisions Expenses**; or
    - Benefits for Autism Spectrum Disorder as described in **Special Provisions Expenses**.

13. Any services or supplies provided for Custodial Care.

14. Any non−surgical (dental restorations, orthodontics, or physical therapy) or non−diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint (including the jaw and craniomandibular joint) and all adjacent or related muscles.

15. Any items of Medical−Surgical Expenses incurred for dental care and treatments, dental surgery, or dental appliances, except as provided for in the ***Benefits for Dental Services*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

16. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the ***Benefits for Cosmetic, Reconstructive, or Plastic Surgery*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

17. Any services or supplies provided for:

    - Treatment of myopia and other errors of refraction, including refractive surgery; or
    - Orthoptics or visual training; or
    - Eyeglasses or contact lenses, provided that intraocular lenses shall be specific exceptions to this exclusion; or
    - Examinations for the prescription or fitting of eyeglasses or contact lenses, except as may be provided under the ***Benefits for Preventive Care*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet; or
    - Restoration of loss or correction to an impaired speech or hearing function, including hearing aids, except as may be provided under the ***Benefits for Speech and Hearing Services*** and ***Benefits for Autism Spectrum Disorder*** provisions in the **Special Provisions Expenses** portion of this Benefit Booklet.

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

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

20. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi−disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the ***Benefits for Autism Spectrum Disorder*** provision in the **Special Provisions Expenses** portion of this Benefit Booklet.

21. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Professional Other Provider.

22. Any services or supplies provided primarily for:

    - Environmental Sensitivity;
    - Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    - Inpatient allergy testing or treatment.

23. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

24. Any services or supplies provided for, in preparation for, or in conjunction with:

    - Sterilization reversal (male or female);
    - Transsexual surgery;
    - Sexual dysfunctions;
    - In vitro fertilization; and
    - Promotion of fertility through extra−coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra−peritoneal insemination, trans−uterine tubal insemination, gamete intra−fallopian transfer, pronuclear oocyte stage transfer, zygote intra−fallopian transfer, and tubal embryo transfer.

25. Any services or supplies in connection with routine foot care, including the removal of warts, corns, or calluses, or the cutting and trimming of toenails in the absence of severe systemic disease.

26. Any services or supplies in connection with foot care for flat feet, fallen arches, and chronic foot strain.

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

28. Services or supplies for smoking cessation programs and the treatment of nicotine addiction.

    NOTE: Refer to your Lifestyle Management Program for information regarding smoking cessation and treatment of nicotine addiction.

29. Any services or supplies provided for the following treatment modalities:

    - acupuncture;
    - intersegmental traction;
    - surface EMGs;
    - spinal manipulation under anesthesia; and
    - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

30. Any covered services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with the Claims Administrator will be paid at the Out–of–Network benefit level.

31. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non–hospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom–made or built–up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts.

    NOTE: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.

32. Any benefits in excess of any specified dollar, day/visit or Calendar Year maximums.

33. Any services and supplies provided to a Participant incurred outside the United States if the Participant traveled to the location for the purposes of receiving medical services, supplies, or drugs.

34. Replacement Prosthetic Appliances except those necessitated by growth due to maturity of the Participant.

35. Private duty nursing services, except for covered Extended Care Expenses.

36. Any drugs and medicines purchased for use outside a Hospital which require a written prescription for purchase other than injectable drugs administered by or under the direct supervision of a Physician or Professional Other Provider.

37. Any services or supplies provided for reduction mammoplasty.

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

39. Any services or supplies provided for the following:

- Cognitive rehabilitation therapy – *Services* designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain–behavioral deficits;
- Cognitive communication therapy – *Services* designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information;
- Neurocognitive rehabilitation – *Services* designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques;
- Neurocognitive therapy – *Services* designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities;
- Neurofeedback therapy – *Services* that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood;
- Post–acute transition services – *Services* that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration; and
- Community reintegration services – *Services* that facilitate the continuum of care as an affected individual transitions into the community.

40. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

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

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

- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers contracting with the Claims Administrator in Texas or any other Blue Cross and Blue Shield Plan*** – The Allowable Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis–related groups (DRG), fee schedule, package pricing, global pricing, per diems, case–rates, discounts, or other payment methodologies.
- ***For Hospitals and Facility Other Providers, Physicians, and Professional Other Providers not contracting with the Claims Administrator in Texas*** – 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 the Claims Administrator. 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 the Claims Administrator. 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 the Claims Administrator. Such factor shall be not less than 75% and shall be updated not less than every two years.

  The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by non–contracted Providers which may also alter the Allowable Amount for a particular service. In the event the Claims Administrator does not have any claim edits or rules, the Claims Administrator 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 the Claims Administrator within ninety (90) days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

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

- ***For multiple surgeries*** – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.
- ***For procedures, services, or supplies provided to Medicare recipients*** – The Allowable Amount will not exceed Medicare's limiting charge.

Autism Spectrum Disorder means a *neurobiological disorder* that includes autism, Asperger's syndrome, or pervasive developmental disorder–not otherwise specified. A *neurobiological disorder* means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

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

Behavioral Health Practitioner means a Physician or Professional Other Provider who renders services for Mental Health Care, Serious Mental Illness or Chemical Dependency, only as listed in this Benefit Booklet.

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Certain Diagnostic Procedures means:

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

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

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

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

Chiropractic Services means any services or supplies provided by or under the direction of a Doctor of Chiropractic.

Claims Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:

1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells);
2. Urine auto injection (injecting one's own urine into the tissue of the body);
3. Skin irritation by Rinkel method;
4. Subcutaneous provocative and neutralization testing (injecting the patient with allergen); or

5. Sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Complications of Pregnancy means:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but *shall not include* false labor, occasional spotting, Physician–prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre–eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

2. Non–elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution with which the Claims Administrator has executed a written contract for the provision of care, services, or supplies furnished within the scope of its license for benefits available under the Plan. A Contracting Facility shall also include a Hospital or Facility Other Provider located outside the State of Texas, and with which any other Blue Cross Plan has executed such a written contract; provided, however, any such facility that fails to satisfy each and every requirement contained in the definition of such institution or facility as provided in the Plan shall be deemed a Non–Contracting Facility regardless of the existence of a written contract with another Blue Cross Plan.

Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Co–Share Amount means the dollar amount of Eligible Expenses including Copayment Amounts incurred by a Participant during a Calendar Year that exceeds benefits provided under the Plan. Refer to **Co–Share Stop–Loss Amount** in **ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS, AND BENEFITS** of the Benefit Booklet for additional information.

Cosmetic, Reconstructive, or Plastic Surgery means surgery that:

1. Can be expected or is intended to improve the physical appearance of a Participant; or
2. Is performed for psychological purposes; or
3. Restores form but does not correct or materially restore a bodily function.

Covered Oral Surgery means maxillofacial surgical procedures limited to:

1. Excision of non–dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess; and
3. Surgical procedures involving salivary glands and ducts and non–dental related procedures of the accessory sinuses.
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an accident, a trauma, a congenital defect, a developmental defect, or a pathology.

Creditable Coverage means coverage provided under:

1. A group health plan that is a self–funded or self–insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974;
2. Health insurance coverage consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital, or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes:
   a. group health insurance coverage;
   b. individual health insurance coverage; and

c. short−term, limited−duration insurance;

3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid) other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines);
5. Title 10 Chapter 55, *United States Code* (medical and dental care for members and certain former members of the uniformed services and for their dependents);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program);
9. A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan;
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. Section 2504 (e)); or
11. Title XXI of the Social Security Act (State Children's Health Insurance Program).

Creditable Coverage does not include:

1. Coverage only for accident (including accidental death and dismemberment);
2. Disability income coverage;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Coverage issued as a supplement to liability insurance;
5. Workers' compensation or similar coverage;
6. Automobile medical payment insurance;
7. Credit−only insurance (for example, mortgage insurance);
8. Coverage for onsite medical clinics;
9. Limited scope dental benefits, vision benefits, or long−term care benefits if they are provided under a separate policy, certificate, or contract of insurance.
10. Flexible spending accounts (FSAs) if they meet the definition of a health FSA in IRC Sec. 106(c)(2) and (a) the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year; and (b) the employee has other coverage available under a group health plan of the employer for the year; and (c) the other coverage is not limited to benefits that are excepted benefits;
11. Coverage for only a specified disease or illness or Hospital indemnity or other fixed indemnity insurance;
12. Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act), also known as Medigap or MedSupp insurance);
13. Coverage supplemental to the coverage provided under Chapter 55, Title 10, *United States Code (*also known as TRICARE supplemental programs); and
14. Similar supplemental coverage provided to coverage under a group health plan.

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

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

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

Dependent means your spouse or any *child* covered under the Plan who is:

1. Under the limiting age shown on your Schedule of Coverage;
2. A *child* of any age who is medically certified as disabled and dependent on the parent for support and maintenance (provided they were covered prior to reaching the Dependent limiting age).

Child means:

a. Your natural child; or

b. Your legally adopted child, including a child for whom the Participant is a party in a suit in which the adoption of the child is sought; or

c. Your stepchild; or

d. A child of your child who is your dependent for federal income tax purposes at the time application of coverage of the child of your child is made; or

e. A child not listed above:

(1) whose primary residence is your household; and
(2) to whom you are legal guardian or related by blood or marriage; and
(3) who is dependent upon you for more than one–half of his support as defined by the Internal Revenue Code of the United States.

For purposes of this Plan, the term *Dependent* will also include those individuals who no longer meet the definition of a Dependent, but are beneficiaries under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

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

1. Diet;
2. Regulation or management of diet; or
3. The assessment or management of nutrition.

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and rehabilitative equipment and is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility 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 the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

Eligible Expenses mean either, Inpatient Hospital Expenses, Medical–Surgical Expenses, Extended Care Expenses, or Special Provisions Expenses, as described in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) 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 lay person, 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:

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

Employee means a person who:

1. Regularly provides personal services at the Employee's usual and customary place of employment with the Employer; and
2. Works a specified number of hours per week or month as required by the Employer; and
3. Is recorded as an Employee on the payroll records of the Employer; and
4. Is compensated for services by salary or wages. If applicable to this group, proprietors, partners, corporate officers and directors need not be compensated for services by salary or wages.

For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Employer means the person, firm, or institution named on this Benefit Booklet.

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

1. Controlled environment; or
2. Sanitizing the surroundings, removal of toxic materials; or
3. Use of special non−organic, non−repetitive diet techniques.

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

Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, 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 Claims Administrator for the Plan 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, the Claims Administrator still may determine such services or supplies to be Experimental/Investigational within this definition. Treatment provided as part of a clinical trial or a research study is Experimental/Investigational.

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

Group Health Plan (GHP) as applied to this Benefit Booklet means a self−funded employee welfare benefit plan as defined in subsection 160.103 of HIPAA. For additional information, refer to the definition of Plan Administrator.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a Health Maintenance Organization that provides benefits for health care services. The term does not include:

1. Accident only or disability income insurance, or a combination of accident–only and disability income insurance;
2. Credit–only insurance;
3. Disability insurance coverage;
4. Coverage for a specified disease or illness;
5. Medicare services under a federal contract;
6. Medicare supplement and Medicare Select policies regulated in accordance with federal law;
7. Long–term care coverage or benefits, home health care coverage or benefits, nursing home care coverage or benefits, community–based care coverage or benefits, or any combination of those coverages or benefits;
8. Coverage that provides limited–scope dental or vision benefits;
9. Coverage provided by a single service health maintenance organization;
10. Coverage issued as a supplement to liability insurance;
11. Workers' compensation or similar insurance;
12. Automobile medical payment insurance coverage;
13. Jointly managed trusts authorized under 29 U.S.C. Section 141, et seq., that;
    - contain a plan of benefits for employees
    - is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees, and
    - is authorized under 29 U.S.C. Section 157;
14. Hospital indemnity or other fixed indemnity insurance;
15. Reinsurance contracts issued on a stop–loss, quota–share, or similar basis;
16. Short–term major medical contracts;
17. Liability insurance, including general liability insurance and automobile liability insurance;
18. Other coverage that is:
    - similar to the coverage described by this subdivision under which benefits for medical care are secondary or incidental to other insurance benefits; and
    - specified in federal regulations;
19. Coverage for onsite medical clinics; or
20. Coverage that provides other limited benefits specified by federal regulations.

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.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

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

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

1. Drugs and IV solutions;

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

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

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

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

1. Licensed in accordance with state law (where the state law provides for such licensing); or
2. Certified by Medicare as a supplier of Hospice Care.

Hospice Care means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.

Hospital means a short–term acute care facility which:

1. Is duly licensed as a Hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint Commission on Accreditation of Healthcare Organizations or is certified as a Hospital provider under Medicare;

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

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

4. Provides 24–hour nursing services by or under the supervision of a Registered Nurse;

5. Has in effect a Hospital Utilization Review Plan; and

6. Is not, other than incidentally, a Skilled Nursing Facility, nursing home, Custodial Care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, Hospice, or place for the provision of rehabilitative care.

Hospital Admission means the period between the time of a Participant's entry into a Hospital or a Chemical Dependency Treatment Center as a *Bed patient* and the time of discontinuance of bed–patient care or discharge by the admitting Physician, Behavioral Health Practitioner or Professional Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24–hour period but is confined as a *Bed patient* in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Claims Administrator.

Bed patient means confinement in a bed accommodation of a Chemical Dependency Treatment Center on a 24–hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and operated to provide acute, short–term Hospital care on a 24–hour basis; the term does not include confinement in a portion of the Hospital (other than a Chemical Dependency Treatment Center) designed, staffed, and operated to provide long–term institutional care on a residential basis.

Identification Card means the card issued to the Employee by the Claims Administrator of the Plan indicating pertinent information applicable to his coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License.

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

In–Network Benefits means the benefits available under the Plan for services and supplies that are provided by a Network Provider or an Out–of–Network Provider when acknowledged by the Claims Administrator.

Inpatient Hospital Expense means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided that such items are:

1. Furnished at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and

2. Provided by a Hospital or a Chemical Dependency Treatment Center; and

3. Furnished to and used by the Participant during an inpatient Hospital Admission.

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

Inpatient Hospital Expense shall include:

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge *is not* an Eligible Expense.

2. All other usual Hospital services, including drugs and medications, which are Medically Necessary and consistent with the condition of the Participant. Personal items *are not* an Eligible Expense.

Medically Necessary Mental Health Care or treatment of Serious Mental Illness in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents, in lieu of hospitalization, shall be Inpatient Hospital Expense.

Late Enrollee means any Employee or Dependent eligible for enrollment who requests enrollment in an Employer's Health Benefit Plan (1) after the expiration of the initial enrollment period established under the terms of the first plan for which that Participant was eligible through the Employer, (2) after the expiration of an Open Enrollment Period, or (3) after the expiration of a special enrollment period.

An Employee or a Dependent is *not* a Late Enrollee if:

1. The individual:
   a. Was covered under another Health Benefit Plan or self–funded Health Benefit Plan at the time the individual was eligible to enroll; and
   b. Declines in writing, at the time of initial eligibility, stating that coverage under another Health Benefit Plan or self–funded Health Benefit Plan was the reason for declining enrollment; and
   c. Has lost coverage under another Health Benefit Plan or self–funded Health Benefit Plan as a result of:

      (1) termination of employment;
      (2) reduction in the number of hours of employment;
      (3) termination of the other plan's coverage;

(4) termination of contributions toward the premium made by the Employer;
(5) COBRA coverage has been exhausted;
(6) cessation of Dependent status;
(7) the individual incurs a claim that would meet or exceed a lifetime limit on all benefits;
(8) the Plan no longer offers any benefits to the class of similarly situated individuals that include the individual; or
(9) in the case of coverage offered through an HMO, the individual no longer resides, lives, or works in the service area of the HMO and no other benefit option is available; and

d. Requests enrollment not later than the 31st day after the date on which coverage under the other Health Benefit Plan or self−funded Health Benefit Plan terminates or in the event of the attainment of a lifetime limit on all benefits, the individual must request to enroll not later than 31 days after a claim is denied due to the attainment of a lifetime limit on all benefits.

2. The individual is employed by an Employer who offers multiple Health Benefit Plans and the individual elects a different Health Benefit Plan during an Open Enrollment Period.
3. A court has ordered coverage to be provided for a spouse under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the court order is issued.
4. A court has ordered coverage to be provided for a child under a covered Employee's plan and the request for enrollment is made not later than the 31st day after the date on which the Employer receives notice of the court order.
5. A Dependent child is not a Late Enrollee if the child:

   a. Was covered under Medicaid or the Children's Health Insurance Program (CHIP) at the time the child was eligible to enroll;
   b. The employee declined coverage for the child in writing, stating that coverage under Medicaid or CHIP was the reason for declining coverage;
   c. The child has lost coverage under Medicaid or CHIP; and
   d. The request for enrollment is made not later than the 31st day after the date on which coverage under Medicaid or CHIP terminates.

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

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

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

1. Social and emotional factors related to the Participant's sickness, need for care, response to treatment, and adjustment to care; and

2. Relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.

Medical−Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided at the usual place of business of the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
3. Billed to the patient by the directing Physician, Behavioral Health Practitioner or Professional Other Provider.

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

Medically Necessary or **Medical Necessity** means those services or supplies covered under the Plan which are:

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

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

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

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

2. The diagnosis or treatment of any symptom, condition, disease, or disorder by a Physician, Behavioral Health Practitioner or Professional Other Provider (or by any person working under the direction or supervision of a Physician, Behavioral Health Practitioner or Professional Other Provider) when the Eligible Expense is:

    a. Individual, group, family, or conjoint psychotherapy,
    b. Counseling,
    c. Psychoanalysis,
    d. Psychological testing and assessment,
    e. The administration or monitoring of psychotropic drugs, or
    f. Hospital visits or consultations in a facility listed in subsection 5, below;

3. Electroconvulsive treatment;

4. Psychotropic drugs;

5. Any of the services listed in subsections 1 through 4, above, performed in or by a Hospital, Facility Other Provider, or other licensed facility or unit providing such care.

Network means identified Physicians, Behavioral Health Practitioner, Professional Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

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

Non−Contracting Facility means a Hospital, a Facility Other Provider, or any other facility or institution which has not executed a written contract with BCBSTX for the provision of care, services, or supplies for which benefits are provided by the Plan. Any Hospital, Facility Other Provider, facility, or institution with a written contract with BCBSTX which has expired or has been canceled is a Non−Contracting Facility.

Open Enrollment Period means the 31−day period preceding the next Plan Anniversary Date during which Employees and Dependents may enroll for coverage.

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

1. **Facility Other Provider** − an institution or entity, only as listed:
   a. Chemical Dependency Treatment Center
   b. Crisis Stabilization Unit or Facility
   c. Durable Medical Equipment Provider
   d. Home Health Agency
   e. Home Infusion Therapy Provider
   f. Hospice
   g. Imaging Center
   h. Independent Laboratory
   i. Prosthetics/Orthotics Provider
   j. Psychiatric Day Treatment Facility
   k. Renal Dialysis Center
   l. Residential Treatment Center for Children and Adolescents
   m. Skilled Nursing Facility
   n. Therapeutic Center

2. **Professional Other Provider** − a person or practitioner, when acting within the scope of his license and who is appropriately certified, only as listed:
   a. Advanced Practice Nurse
   b. Doctor of Chiropractic
   c. Doctor of Dentistry
   d. Doctor of Optometry
   e. Doctor of Podiatry
   f. Doctor in Psychology
   g. Licensed Acupuncturist
   h. Licensed Audiologist
   i. Licensed Chemical Dependency Counselor
   j. Licensed Dietitian
   k. Licensed Hearing Instrument Fitter and Dispenser
   l. Licensed Marriage and Family Therapist
   m. Licensed Clinical Social Worker
   n. Licensed Occupational Therapist
   o. Licensed Physical Therapist
   p. Licensed Professional Counselor
   q. Licensed Speech−Language Pathologist
   r. Licensed Surgical Assistant
   s. Nurse First Assistant
   t. Physician Assistant
   u. Psychological Associates who work under the supervision of a Doctor in Psychology

In states where there is a licensure requirement, other Providers must be licensed by the appropriate state administrative agency.

Out−of−Network Benefits means the benefits available under the Plan for services and supplies that are provided by an Out−of−Network Provider.

Out−of−Network Provider means a Hospital, Physician, Behavioral Health Practitioner 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 Contraceptive Services means a consultation, examination, procedure, or medical service that is provided on an outpatient basis and that is related to the use of a drug or device intended to prevent pregnancy.

Participant means an Employee or Dependent whose coverage has become effective under this Plan.

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.

Plan means a program of health and welfare benefits established for the benefit of its Participants whether the plan is subject to the rules and regulations of the Employee's Retirement and Income Security Act (ERISA) or, for government and/or church plans, where compliance is voluntary.

Plan Administrator means the the Group Health Plan (GHP) or a named administrator of the Plan having fiduciary responsibility for its operation. BCBSTX is not the Plan Administrator.

Plan Anniversary Date means the day, month, and year of the 12−month period following the Plan Effective Date and corresponding date in each year thereafter for as long as this Benefit Booklet is in force.

Plan Effective Date means the date on which coverage for the Employer's Plan begins with the Claims Administrator.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for **Managed Health Care Plan** benefits.

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

Preexisting Condition means a condition for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the earlier of the:

- Effective Date of Coverage; or
- First day of the Waiting Period.

Proof of Loss means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and
3. Correct diagnosis code(s) and procedure code(s) for the services and items.

Prosthetic Appliances means artificial devices including limbs or eyes, braces or similar prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the

function of a permanently inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Appliance.

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

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

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

Renal Dialysis Center means a facility which is Medicare certified as an end–stage renal disease facility providing staff assisted dialysis and training for home and self–dialysis.

Residential Treatment Center for Children and Adolescents means a child–care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

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

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

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claims Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:

1. An ambulatory (day) surgery facility;
2. A freestanding radiation therapy center; or
3. A freestanding birthing center.

Waiting Period means a period established by an Employer that must pass before an individual who is a potential enrollee in a Health Benefit Plan is eligible to be covered for benefits.

GENERAL PROVISIONS

Agent

The Employer is not the agent of the Claims Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between TAC HEBP and the Claims Administrator. No notice to or consent by any Participant is necessary to amend or change the Plan.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claims Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claims Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claims Administrator, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Disclosure Authorization

If you file a claim for benefits, it will be necessary that you authorize any health care Provider, insurance carrier, or other entity to furnish the Claims Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Medicare

Special rules apply when you are covered by this Plan and by Medicare. Generally, this Plan is a Primary Plan if you are an active Employee, and Medicare is a Primary Plan if you are a retired Employee.

Participant/Provider Relationship

The choice of a health care Provider should be made solely by you or your Dependents. The Claims Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claims Administrator is not liable for any act or omission by any health care Provider. The Claims Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the health care Provider selected and are available only for sickness or injury treatment acceptable to the health care Provider.

The Claims Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claims Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claims Administrator does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund of Benefit Payments

If the Claims Administrator pays benefits for Eligible Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, the Claims Administrator may deduct any refund due it from any future benefit payment.

Subrogation

If the Plan pays or provides benefits for you or your Dependents, the Plan is subrogated to all rights of recovery which you or your Dependent have in contract, tort, or otherwise against any person, organization, or insurer for the amount of benefits the Plan has paid or provided. That means the Plan may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

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

Right of Reimbursement

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

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of benefits paid or provided by the Plan.

Right to Recovery by Subrogation or Reimbursement

You or your Dependent agree to promptly furnish to the Plan all information which you have concerning your rights of recovery from any person, organization, or insurer and to fully assist and cooperate with the Plan in protecting and obtaining its reimbursement and subrogation rights. You, your Dependent or your attorney will notify the Plan before settling any claim or suit so as to enable us to enforce our rights by participating in the settlement of the claim or suit. You or your Dependent further agree not to allow the reimbursement and subrogation rights of the Plan to be limited or harmed by any acts or failure to act on your part.

Coordination of Benefits

The availability of benefits specified in This Plan is subject to Coordination of Benefits (COB) as described below. This COB provision applies to This Plan when a Participant has health care coverage under more than one Plan.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan shall not be reduced when This Plan determines its benefits before another Plan; but may be reduced when another Plan determines its benefits first.

Coordination of Benefits – Definitions

1. **Plan** means any group insurance or group–type coverage, whether insured or uninsured. This includes:

    a. group or blanket insurance;
    b. franchise insurance that terminates upon cessation of employment;
    c. group hospital or medical service plans and other group prepayment coverage;

d. any coverage under labor–management trustee arrangements, union welfare arrangements, or employer organization arrangements;
e. governmental plans, or coverage required or provided by law.

Plan does *not* include:
a. any coverage held by the Participant for hospitalization and/or medical–surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy;
b. a policy of health insurance that is individually underwritten and individually issued;
c. school accident type coverage; or
d. a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

2. **This Plan** means the part of this Benefit Booklet that provides benefits for health care expenses.

3. **Primary Plan/Secondary Plan**
The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the Participant. A *Primary Plan* is a Plan whose benefits are determined before those of the other Plan and without considering the other Plan's benefit. A *Secondary Plan* is a Plan whose benefits are determined after those of a Primary Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the Participant, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

4. **Allowable Expense** means a necessary, reasonable, and customary item of expense for health care when the item of expense is covered at least in part by one or more Plans covering the Participant for whom claim is made.

5. **Claim Determination Period** means a Calendar Year. However, it does not include any part of a year during which a Participant has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

6. **We** or **Us** means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. **General Information**

a. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless (a) the other Plan has rules coordinating its benefits with those of This Plan, and (b) both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

b. If this Benefit Booklet contains any dental or vision benefits, the benefits provided by the health portion of This Plan will be the Secondary Plan.

2. **Rules**
This Plan determines its order of benefits using the first of the following rules which applies:

a. ***Non–Dependent/Dependent.*** The benefits of the Plan which covers the Participant as an Employee, member or subscriber are determined before those of the Plan which covers the Participant as a Dependent. However, if the Participant is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:

(1) secondary to the Plan covering the Participant as a Dependent and

(2) primary to the Plan covering the Participant as other than a Dependent (e.g., a retired Employee), then the benefits of the Plan covering the Participant as a Dependent are determined before those of the Plan covering that Participant other than a Dependent.

b. ***Dependent Child/Parents Not Separated or Divorced.*** Except as stated in Paragraph c below, when This Plan and another Plan cover the same child as a Dependent of different parents:

(1) The benefits of the Plan of the parent whose birthday falls earlier in a Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

(2) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in this Paragraph b, but instead has a rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

c. ***Dependent Child/Parents Separated or Divorced.*** If two or more Plans cover a Participant as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

(1) First, the Plan of the parent with custody of the child;
(2) Then, the Plan of the spouse of the parent with custody, if applicable;
(3) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Calendar Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

d. ***Joint Custody.*** If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined in Paragraph b.

e. ***Active/Inactive Employee.*** The benefits of a Plan which covers a Participant as an Employee who is neither laid off nor retired are determined before those of a Plan which covers that Participant as a laid off or retired Employee. The same would hold true if a Participant is a Dependent of a person covered as a retired Employee and an Employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Paragraph e does not apply.

f. ***Continuation Coverage.*** If a Participant whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another Plan, the following shall be the order of benefit determination:

(1) First, the benefits of a Plan covering the Participant as an Employee, member or subscriber (or as that Participant's Dependent);

(2) Second, the benefits under the continuation coverage.

If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits this Paragraph f does not apply.

g. ***Longer/Shorter Length of Coverage.*** If none of the above rules determine the order of benefits, the benefits of the Plan which covered an Employee, member or subscriber longer are determined before those of the Plan which covered that Participant for the shorter period of time.

Effect on the Benefits of This Plan

1. **When This Section Applies**
   This section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this section.

2. **Reduction in this Plan's Benefits**
   The benefits of This Plan will be reduced when the sum of:

   a. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and

   b. The benefits that would be payable for the Allowable Expense under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made exceeds those Allowable Expenses in a Claim Determination Period.

   In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

   When the benefits of This Plan are reduced as previously described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

We assume no obligation to discover the existence of another Plan, or the benefits available under the other Plan, if discovered. We have the right to decide what information we need to apply these COB rules. We may get needed information from or release information to any other organization or person without telling, or getting the consent of, any person. Each person claiming benefits under This Plan must give us any information concerning the existence of other Plans, the benefits thereof, and any other information needed to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

Right to Recovery

If the amount of the payments We make is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. the persons We have paid or for whom We have paid;
2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

The Claims Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claims Administrator will not always know of the events causing termination until after the events have occurred.

Termination of Individual Coverage

Coverage under the Plan for you and/or your Dependents will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or
2. You no longer satisfy the definition of an Employee as defined in this Benefit Booklet, including termination of employment; or
3. The Plan is terminated or the Plan is amended, at the direction of the Plan Administrator, to terminate the coverage of the class of Employees to which you belong; or
4. A Dependent ceases to be a Dependent as defined in the Plan.

However, when any of these events occur, you and/or your Dependents may be eligible for continued coverage. See **Continuation of Group Coverage – Federal** in the **GENERAL PROVISIONS** section of this Benefit Booklet.

The Claims Administrator may refuse to renew the coverage of an eligible Employee or Dependent for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a child of any age who is medically certified as *Disabled* and dependent on the parent will not terminate upon reaching the limiting age shown in your Schedule of Coverage if the child continues to be both:

1. *Disabled*, and
2. Dependent upon you for more than one–half of his support as defined by the Internal Revenue Code of the United States.

Disabled means any medically determinable physical or mental condition that prevents the child from engaging in self–sustaining employment. The disability must begin while the child is covered under the Plan and before the child attains the limiting age. You must submit satisfactory proof of the disability and dependency through your Plan Administrator to the Claims Administrator within 31 days following the child's attainment of the limiting age. As a condition to the continued coverage of a child as a *Disabled* Dependent beyond the limiting age, the Claims Administrator may require periodic certification of the child's physical or mental condition but not more frequently than annually after the two–year period following the child's attainment of the limiting age.

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan.

Notice of Creditable Coverage

Upon termination of your coverage under this Plan, you will be issued a Certificate of Creditable Coverage. You may request a Certificate of Creditable Coverage within 24 months of termination of your or your Dependent's coverage under this Plan.

Continuation of Group Coverage – Federal

COBRA Continuation – Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Minimum Size of Group

The Group must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full–time and part–time employees employed, not the number of employees covered by a Health Benefit Plan.

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cease.

A covered Dependent may elect to continue coverage for thirty–six (36) months from the date coverage would otherwise cease if coverage terminates as the result of:

1. divorce from the covered Employee,

2. death of the covered Employee,

3. the covered Employee becomes eligible for Medicare, or

4. a covered Dependent child no longer meets the Dependent eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events which have a maximum continuation period of eighteen (18) months.

2. The last day of the thirty–six (36) month period for events which have a maximum continuation period of thirty–six (36) months.

3. The first day for which timely payment of contribution is not made to the Plan with respect to the qualified beneficiary.

4. The Group Health Plan is canceled.

5. The date, after the date of the election, upon which the qualified beneficiary first becomes covered under any other group health plan.

6. The date, after the date of the election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty–six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty–six (36) months from the initial qualifying event.

If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty–nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Notice of COBRA Continuation Rights

The Employer is responsible for providing the necessary notification to Participants as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 and the Tax Reform Act of 1986.

For additional information regarding your rights under COBRA continuation, refer to the Continuation Coverage Rights Notice in the **NOTICES** section of this Benefit Booklet.

AMENDMENTS

NOTICES

TEXAS ASSOCIATION OF COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL
NOTICE OF WELLNESS PROGRAMS

The Texas Association of Counties Health and Employee Benefits Pool (TAC HEBP) is dedicated to providing consistent, valuable services and support to our members. To continue in this effort, we developed a statewide wellness initiative called Healthy County.

Healthy County is a three-way partnership that includes:

- **TAC HEBP** providing access to the best programs and resources;
- **Employers** investing in employee health by providing benefits programs; and
- **Employees** committing to a healthy lifestyle and making responsible health decisions.

TAC HEBP has partnered with Blue Cross Blue Shield of Texas to process medical claims and provide access to the largest network of providers in the state. Together, TAC HEBP and BlueCross BlueShield of Texas are working to develop programs and tools that complement the quest for healthy living at no cost to you. Below are a list of features, service, and resources that add value to your health plan.

24-Hr Nurseline

Use this toll-free number to speak with experienced registered nurses who can help with your health care concerns.

- Call (866) 412-8795, option 3. This number is also on the back of your BCBSTX / TAC insurance card.

Benefits & Wellness Portal

Review your health, dental and life benefit elections and access online wellness programs.

How to Access:

- Log on to mybenefits.county.org; and
- Enter the last nine numeric digits of your user Id (UID) located on your BCBSTX / TAC Insurance card and password.

Blue Care Connection

With the Blue Care Connection Program, getting connected to your health benefits is now easier than ever. Blue Care Connection offers you the information and help you need to manage everything from basic health issues to chronic health conditions.

Condition Management

This voluntary health improvement program helps members who have any of the following conditions: cancer, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, asthma, diabetes, metabolic syndrome and low back pain. The program teaches strategies to better manage these chronic conditions.

- Call (866) 412-8795, option 4

Colonoscopy Benefit

In-network benefits for tests for colorectal cancer are covered at 100 percent of allowable amount with deductible waived. This benefit includes all places of treatment and diagnoses. Physician office visits preceding the test will require office visit co-pay.

Medicine Match

Medicine Match is one of TAC HEBP's programs designed to make treating asthma, diabetes, cholesterol and high blood pressure more affordable. When you enroll in the Condition Management program for one of these conditions, you become eligible for a 50 percent reduction in co-pay for covered medications that treat these conditions. The end result—better health and lower long term cost for you.

To participate in the medicine match program, please call 1-866-412-8795 and choose option 4 to enroll in the Condition Management for one of the four covered conditions listed above. Within two weeks of enrolling in Condition Management, you will automatically receive a 50 percent copay reduction on your medication.

Special Beginnings Maternity Management Program

Establish ongoing contact with obstetric nurses who provide prenatal risk assessment and coordinate with your provider. Program offers expectant mothers confidential support through every stage of pregnancy.

- Call (888) 421-7781

Personal Health Manager (PHM)

Want to manage your health online and earn Blue Points? Use the PHM to track a fitness workout, report a meal, complete the online health risk assessment, participate in a fitness program and more. Blue Points are redeemable for a variety of electronics, health and wellness products, and other rewards.

How to Access:

- Log on to mybenefits.county.org;
- Click "Get Connected;"
- Click BCBSTX link; and
- Click Personal Health Manager link.

Health Risk Assessment (HRA)

Learn about your overall health status and specific health issues such as sleep and nutrition, as well as helpful tips.

How to Access:

- Log on to mybenefits.county.org;
- Click "Get Connected;"
- Click BCBSTX link;
- Click Personal Health Manager link; and
- Click link to take Health Risk Assessment.

Fitness Program

Available exclusively to TAC HEBP and BCBSTX members along with their covered dependents (age 18 and older), the Fitness Program provides:

- **Unlimited** access to a nationwide network of participating independently contracted fitness centers and select YMCA locations;
- **Flexible** membership, no long-term contract required. There is a one-time enrollment fee of $29, then $29 a month;
- **Easy** online enrollment; automatic monthly payment withdrawal;
- **View** your fitness center visits online; and
- **Earn** Blue Points^{SM} rewards – up to 400 per week.

Blue Care Advisor

A multi-disciplinary team of Registered Nurses, Licensed Professional Counselors, and Master level Social Workers who assist selected members in navigating the health care system; coordinates member's health care and benefits; educates and empowers members to make informed choices; promotes wellness by encouraging self-management according to preventive care guidelines.

- *C*all (866) 412-8795, option 2

Lifestyle Management & Wellness programs

These programs are targeted wellness initiatives that can help prevent diseases or identify them early when they are more treatable.

- *C*all (866) 412-8795, option 2

Tobacco Cessation

Voluntary program that provides online tools, support, personal coaching and discounts for wellness-related products and services to help you quit smoking.

How to Access:

- Call (866) 412-8795, option 2 for Lifestyle Management; or
- Log on to mybenefits.county.org;
- Click “Get Connected;”
- Click BCBSTX link;
- Click Personal Health Manager link; and
- Click Stop Smoking link.

Tobacco Cessation Prescription Benefit

- One co-pay of $30 per prescription;
- Mail order allowed at $90 for a three-month supply;
- Rx deductible waived; and
- No over-the-counter drugs are covered.

*The drug information provided here is for benefit notification only. Consult your medical professional for guidance regarding appropriate usage and possible side effects before utilizing any prescription drug.

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

BlueCard

Blue Cross and Blue Shield of Texas hereby informs you that other Blue Cross and Blue Shield Plans outside of Texas ("Host Blues") may have contracts similar to the contracts described above with certain Providers ("Host Blue Providers") in their service areas.

When you access health care services through BlueCard outside of Texas and from a Provider which does not have a contract with Blue Cross and Blue Shield of Texas, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue passes on to Blue Cross and Blue Shield of Texas.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. Sometimes, however, it is an estimated price that takes into consideration the actual price increased or reduced to reflect aggregate payment from expected settlements, withholds, any other contingent payment arrangements and non−claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be charged as a billed charge reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over− or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above or require a surcharge, Blue Cross and Blue Shield of Texas would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTICE

The Women's Health and Cancer Rights Act of 1998 requires this notice. This Act is effective for plan year anniversaries on or after October 21, 1998. This benefit may already be included as part of your coverage.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Deductibles, Co–Share and copayment amounts will be the same as those applied to other similarly covered medical services, such as surgery and prostheses.

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it**.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent–employee dies;
- The parent–employee's hours of employment are reduced;
- The parent–employee's employment ends for any reason other than his or her gross misconduct;
- The parent–employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides health care coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Contact your employer and/or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18–month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18–MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

SECOND QUALIFYING EVENT EXTENSION OF 18–MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights, should be addressed to your Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Contact your employer for the name, address and telephone number of the party responsible for administering your COBRA continuation coverage.

TEXAS ASSOCIATION of COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL

NOTICE OF PRIVACY PRACTICES

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

I.
USE AND DISCLOSURE OF HEALTH INFORMATION

The Texas Association of Counties Health and Employee Benefits Pool ("Pool") has created a health plan that provides health coverages for employees (and their dependents) of the counties and county-related entities that are members of the Pool ("the Plan"). The Plan is subject to the requirements of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Privacy Rule published by the United States Department of Health and Human Services at 45 CFR §§ 160 - 164 ("Privacy Rule"). HIPAA and the Rule regulate the Plan's use of your protected health information.

The Plan may use your protected health information for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED WITHOUT GETTING AN AUTHORIZATION FROM YOU OR GIVING YOU A CHANCE TO AGREE OR OBJECT TO THE DISCLOSURE:

A. To Make or Obtain Payment.

The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

B. To Conduct Health Care Operations.

The Plan may use or disclose health information for its own health care operations, to facilitate the administration of the Plan, and as necessary to provide coverage and services to all of the Plan's participants. If the Plan needs to use your information, but does not need to disclose it to third parties, it will be used but will not be disclosed. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or similar activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development, including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

For example, the Plan may use your health information to conduct case management reviews, to review and assess the quality of the various components of the Plan and the utilized health care providers, or to engage in customer service and grievance resolution activities.

C. For Treatment Alternatives.

The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

D. For Distribution of Health-Related Benefits and Services.

The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

E. For Disclosure to the Plan Sponsor.

The Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plan also may disclose to the plan sponsor information on whether you are participating in the health plan.

In addition, the Plan may disclose your protected health information (PHI) to the plan sponsor as necessary for the plan sponsor to perform administration functions on behalf of the Plan. The Plan will not provide your name in connection with your health information and will otherwise de-identify the information to the extent it is practical to do so. PHI will be disclosed to the plan sponsor only upon receipt of a certification by the plan sponsor that the plan sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;
- Ensure that any agents to whom it provides PHI received from HEBP agree to the same restrictions that apply to the plan sponsor with respect to such information;
- Not use or disclose the information for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;
- Report to HEBP any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI for amendment and incorporate any amendments to PHI agreed to or required by HEBP;
- Make PHI available to an individual who has a right to access it pursuant to the Privacy Rule;
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received form HEBP available to the Secretary for purposes of determining compliance by HEBP with the Privacy Rule; and
- If feasible, return or destroy all PHI received from HEBP that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made; and

Any PHI disclosed by the Plan will be disclosed to the Pool Coordinator designated by the Plan Sponsor. The Plan Sponsor will restrict access to and use of PHI to those individuals who need it to perform plan administration functions or to obtain bids for health coverage. The plan sponsor will provide an effective mechanism for resolving any issues if such persons use or disclose your PHI inappropriately.

F. When Legally Required.

The Plan will disclose your health information when it is required to do so by any federal, state or local law.

G. To Conduct Health Oversight Activities.

The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

H. In Connection With Judicial and Administrative Proceedings.

The Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

I. For Law Enforcement Purposes.

As permitted or required by state law, the Plan may disclose your protected health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

J. In the Event of a Serious Threat to Health or Safety.

The Plan may, consistent with applicable law and ethical standards of conduct, disclose your protected health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

K. For Specialized Government Functions.

We may be required to disclose your information to federal authorities. Federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

L. For Worker's Compensation.

The Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

M. Public Health Activities.

The Plan may disclose your protected health information to a public health authority authorized by law to collect such information to prevent or control disease, injury, or disability, and to report such information as birth or death, the conduct of public health surveillance and public health investigations. The Plan also may disclose your information to an appropriate government authority authorized to receive reports about child abuse. The Plan also may disclose your information to a person responsible for activities related to the quality, safety and effectiveness of products regulated by the federal Food and Drug Administration. The Plan may disclose your protected health information to a government authority if there is a reasonable belief that you are a victim of abuse, neglect, or domestic violence.

II.
AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Plan will not disclose your health information unless you give us your written authorization. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time, unless the Plan has taken an action based on your authorization.

III.
YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Plan maintains:

A. Right to Request Restrictions.

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. The Plan is not required to agree to your request, but will certainly consider it. If you wish to make a request for restrictions, please contact TAC HEBP Program Manager at 800-456-5974.

B. Right to Receive Confidential Communications.

You have the right to request that the Plan communicate with you in a certain way if you feel it is necessary to protect your interests. For example, you may ask that the Plan only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to TAC HEBP Program Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. The Plan will honor your reasonable requests for confidential communications.

C. Right to Inspect and Copy Your Health Information.

You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to TAC HEBP Program Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

D. Right to Amend Your Health Information.

If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend any records in its possession. A request for an amendment of records must be made in writing, must express a reason the records should be amended, and must be sent to TAC HEBP Program Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the information requested is not part of a designated record set, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy (including psychotherapy notes, and information compiled for or in anticipation of a civil, criminal or administrative proceeding), or if the Plan determines the records containing your health information are accurate and complete.

E. Right to an Accounting.

The Privacy Rule requires the Plan to keep a record of certain disclosures of health information, such as disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. You have the right to request a copy of this record. The request must be made in writing to TAC HEBP Program Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

F. Right to a Paper Copy of this Notice.

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact TAC HEBP Program Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. You also may view a copy of the current version of the Plan's Privacy Notice at the Web site, http://www.County.Org.

IV.
DUTIES OF TAC HEBP HEALTH PLAN

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to TAC HEBP Privacy Official, Rex Hall, P.O. Box 2131, Austin, Texas 78768, Fax: 512-478-0519. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Plan has designated Rex Hall, Privacy Official as its contact person for all issues regarding patient privacy and your privacy rights. You may contact him at P.O. Box 2131, Austin, Texas 78768, 512-478-8753.

EFFECTIVE DATE

This Notice is effective July 30, 2012.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT Rex Hall, TAC HEBP Privacy Official, P.O. Box 2131, Austin, Texas 78768, 512-478-8753.

PRESCRIPTION DRUG BENEFITS

Your prescription drug benefits are independent of your medical benefits and are administered by CVS/Caremark. For questions or assistance, you may call CVS/Caremark at 800-552-8159 Monday -Friday 7:30 am to 9 pm, Saturday 8 am to 8 pm and Sunday 8 am to 4:30 pm (Central Time) or visit www.caremark.com.

I. Prescription Drugs:

Definitions:
Copayment or Copayment Amount means the amount paid by the Insured Person for each Prescription Order dispensed or refilled at a Participating Pharmacy.
Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for a drug product they sell to a pharmacy.
Brand Name means a prescription drug protected by a registered trademark.
Generic means a prescription drug not protected by a registered trademark.
Heritable Disease means an inherited disease that may result in mental or physical retardation.
Maximum Allowable Cost (MAC) means the maximum cost for which a Participating Pharmacy will be reimbursed by the Administrator for selected products.
MAC List means a list of approximately 80% of the most commonly dispensed drugs that have generic equivalents. Only products rated therapeutically equivalent by the U.S. Food and Drug Administration (as most recently published) are included.
Network means a group of independent pharmacies or chain of pharmacies having a particular agreement for providing prescription drug services in a Network chosen for this Policy. The Network for the Policy is chosen by the Pool.
Non-Participating Pharmacy means a pharmacy which has not entered into an agreement to provide prescription drug services in the Network chosen for this Policy.
Non-Preferred Brand Name means a Brand Name Drug that is not preferred by the Pool and that is subject to the Non-Preferred Brand Name Drug Copayment.
Participating Pharmacy means an independent pharmacy or chain of pharmacies which has entered into an agreement to provide prescription drug services in the Network chosen for this Policy.
Pharmacy Reasonable Charge means either: (1) the usual and customary amount charged by the pharmacy; (2) the acquisition cost plus an industry standard mark-up as determined by the Administrator; (3) the MAC List; or (4) the Average Wholesale Price less, a contractually determined discount amount, plus a dispensing fee determined by the Administrator.
Phenylketonuria means an inherited condition that may cause severe mental retardation if not treated.
Preferred Brand Name means a Brand Name Drug that is preferred by the Pool and that is subject to the Preferred Drug Copayment. Drugs that do not appear on the Preferred Brand Name Drug List will be subject to the Non-Preferred Brand Name Drug Copayment.
Prescription Order means a written or verbal order from a Physician to a pharmacist for a drug or device to be dispensed.
Specialty Drugs means certain pharmaceuticals and/or biotech or biological drugs that are used in the management of specific chronic or genetic disease, including but not limited to, injectible, infused, or oral medications, or otherwise require special handling.

Benefits:
Benefits are payable for expenses for covered outpatient prescription drugs, subject to the provisions, limitations, exclusions and conditions of this coverage document. Such benefits are not subject to the Medical Plan Deductible, however, if your prescription plan has a deductible, you must meet that deductible before benefits will be paid. Charges for outpatient prescription drugs do not apply to the Coinsurance Maximum for Covered Expenses from Preferred Providers.

The following prescription expenses are covered when dispensed by a licensed pharmacist and prescribed by a Physician for use by an Insured Person:
a. drugs and medicines, which by law, can only be obtained with a Prescription Order;
b. injectable insulin and insulin analogs;
c. formulas necessary for the treatment of Phenylketonuria or other Heritable Diseases;
d. prescription contraceptive drugs.
e. specialty drugs are covered only when dispensed through the Mail-Order pharmacy.
f. prescription tobacco-cessation drugs (over-the-counter not included)
- one copay of $30 for one-month supply
- mail order allowed, $90 for a three -month supply
- deductible waived if applicable

Participating Pharmacy and Mail Order Program:
To obtain a covered prescription drug at a Participating Pharmacy, an Insured Person must: (1) present a current, valid Identification Card; (2) pay to the pharmacy the appropriate Copayment Amount for the drugs received; (3) provide a valid Prescription Order; and (4) provide the necessary recipient information and signatures required by the pharmacy. The Administrator will pay the Participating Pharmacy an equal to the contractually agreed to amount, less the appropriate Copayment Amount.

Identification Cards for each Insured Person will be provided. The Identification Card must be presented to a Participating Pharmacy in order for an Insured Person to receive full program benefits. The card will contain information needed by the Participating Pharmacy to identify the Insured Person and the Pool Policy. A Participating Pharmacy is not permitted to file claims for reimbursement unless the card is presented at the time prescription drugs are received from the Pharmacy.

To obtain a covered prescription drug through the Mail Order program, an Insured Person must present a valid Prescription Order and pay the appropriate Copayment Amount. Orders will usually be shipped within two days of the receipt of the Prescription Order.

The applicable drug Copayment Amount per prescription must be paid by an Insured Person before prescription drug benefits are payable through a Participating Pharmacy or the Mail Order program.

The drug Retail Pharmacy Copayment Amount per prescription, for each 30-day supply, is:

Generic Drugs:	$7.00
Preferred Brand Name Drugs:	$25.00
Non-Preferred Brand Name Drugs:	$40.00

The Mail Order Pharmacy Copayment Amount per prescription, up to a 90-day supply, is:

Generic Drugs:	$14.00
Preferred Brand Name Drugs:	$50.00
Non-Preferred Brand Name Drugs:	$80.00

If a Generic Drug is not available or the Prescription Order is marked “dispense as written” for the Brand Name Drug by the Physician, the Insured Person will pay only the applicable Preferred Brand Name Drug or Non-Preferred Brand Name Drug Copayment. If the Insured Person receives the Brand Name Drug when a Generic Drug is available and the Prescription Order is not marked “dispense as written” by the Physician, the Insured Person will be required to pay the applicable Brand Name Drug Copayment plus the difference between the cost of the pharmacy’s Maximum Allowable Cost for the Generic Drug and the cost of the Brand Name Drug. A covered prescription will not exceed a 90-day supply. The Copayment Amount for a greater than 30-day supply is the applicable amount shown above, multiplied by the total number of months covered by the Prescription Order, not to exceed a 90-day supply.

Non-Participating Pharmacy:
When an Insured Person obtains prescription drugs under a valid Prescription Order at a Non-Participating Pharmacy, the Insured Person must pay the charges of the pharmacy and submit a claim to the Administrator. The Administrator will pay a benefit equal to 80% of the network price of the prescription drug minus the appropriate copay amount.

A covered prescription will not exceed a 90-day supply.

Exclusions:

In addition to the limitations otherwise listed in the Policy, Covered Expenses under this Benefit WILL NOT INCLUDE charges for:

a. Drugs or medications that can be lawfully obtained without a Prescription Order, except insulin and insulin analogs.
b. Any charge incurred for the administration of prescription drugs by a Physician, except in connection with diabetes self-management training programs and outpatient contraceptive services.
c. Drugs and substances that are Experimental or Investigational in nature.
d. Drugs taken or given while an Insured Person is confined on an inpatient or outpatient basis in a Hospital, extended care facility, Skilled Nursing Home or similar institution that has a facility for providing drugs.
e. Refill of a prescription for more than the number of times specified by the Physician; or refill dispensed after one year from the order of the physician.
f. Any quantity of drugs or medicines dispensed that, when taken according to the direction of the Physician, exceeds a 90-day supply.
g. Dietary supplements (except for treatment of Insured Persons with Phenylketonuria, other Heritable Diseases, chronic illness, cancer or HIV/AIDS), cosmetic, health and beauty aids.
h. Charges for drugs in excess of the contracted amount.
i. Therapeutic devices or appliances, support garments and other non-medical items regardless of their intended use, except as provided for treatment of diabetes.
j. Minoxidil when prescribed for hair loss.
k. Cosmetic drugs, including Retin-A over age 25.
l. Blood and blood plasma.
m. Appetite suppressants or any other drugs prescribed for weight loss.
n. Injectable drugs for treatment of allergies.
o. Infertility medications.
p. Drugs or medications for treatment of sexual dysfunctions or disorders.
q. Biological sera.
r. Drugs or medications prescribed for an Injury or Illness arising out of employment.
s. Drugs or medications furnished by any government organization or agency unless there is an unconditional legal obligation on the part of the Insured Person to pay such expenses, except Medicaid.
t. Prescription Orders written by Physicians located outside the United States to be dispensed in the United States.
u. Drugs or medications prescribed for treatment of Chemical Dependency. Charges for drugs or medications prescribed for treatment of Chemical Dependency are covered under the Chemical Dependency benefit of this Policy.
v. Drugs, including abortifacients, or devices intended to terminate a pregnancy.
w. Specialty drugs when filled at a retail pharmacy.

Texas Association of Counties Health and Employee Benefits Pool
Notice of Grievance Procedures for Grandfathered Plans

Information regarding claim reviews and preauthorization appeals is found in the ***Claim Filing and Appeals Procedures*** section of your medical benefit booklet. If you do not agree with the amount paid or determination made by the Claims Administrator, you may request a benefit exception.

STEP 1: You must first submit your appeal in writing and follow the process described in the Claim Filing Appeals Procedures section of your medical benefit booklet.

STEP 2: If you are not satisfied with the Claims Administrator's response in Step 1, you may submit a benefit exception request to a Grievance Committee of the Health and Employee Benefits Pool. This committee is comprised of three members of the Health and Employee Benefits Pool's Board of Directors and is independent of the Claims Administrator. Your request must be received at the following address within sixty (60) calendar days from time you were notified of the Claims Administrator's response to your appeal:

Texas Association of Counties Health and Employee Benefits Pool
Grievance Committee
P.O. Box 2131
Austin, TX 78768-2131
Fax: (512) 481-8481

Within forty-five (45) business days after your request is received, the Grievance Committee will meet to consider your request. Although you cannot attend, you will be provided with written notice of the date, time and location of their meeting. The decision of the Grievance Committee is final and you will be notified in writing of their decision within ten (10) days after their meeting.

If prompt action is required to address a serious medical need of a participant or to avoid undue expense to the Pool, and it is impractical for the Grievance Committee to meet promptly, the Chairman of the Board, or his designee, is authorized to make decisions on benefit exception requests.