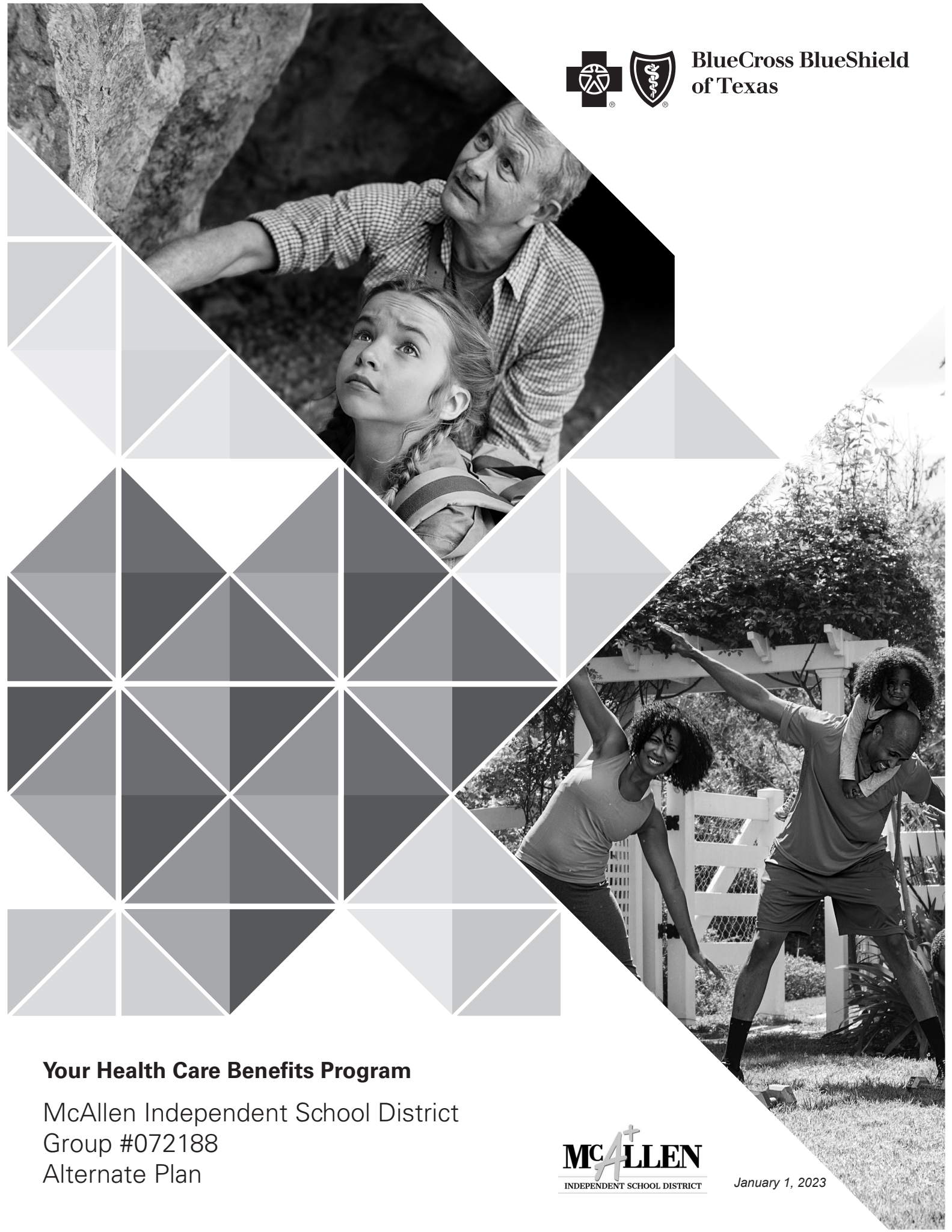




BlueCross BlueShield
of Texas



Your Health Care Benefits Program

McAllen Independent School District
Group #072188
Alternate Plan



January 1, 2023

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SCHEDULE OF COVERAGE

Facilities and Professional Providers	Benefits
Inpatient Services <ul style="list-style-type: none"> Daily Allowance Benefit Days per Benefit Period Includes regular Inpatient Admissions, Mental Health Care, and treatment of Chemical Dependency 	<p style="text-align: center;">\$250</p> <p style="text-align: center;">365 days</p>
Outpatient Surgical Expenses	<p style="text-align: center;">100% of Billed Charges up to \$100 maximum amount per surgical procedure</p>
Professional Providers Only	Benefits
Chemotherapy and Radiation Therapy	<p style="text-align: center;">100% of Billed Charges up to \$1,500 maximum amount per Calendar Year</p>
Preventive Care	<p style="text-align: center;">100% of Billed Charges up to \$200 maximum amount per Calendar Year</p>
Prescription Drugs	Benefits
Prescription drugs received from a retail pharmacy	<p style="text-align: center;">100% of Billed Charges up to \$500 maximum amount per Calendar Year</p>
Dependents are not eligible for coverage under this Plan.	

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 certain Eligible Expenses. 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.

Benefits

Benefits are provided for Inpatient Hospital Expenses, Outpatient Surgical Expenses, Chemotherapy, Radiation Therapy, and Preventive Care as explained in the **BENEFITS PROVIDED** section and shown on your Schedule of Coverage in this Benefit Booklet. Benefits for Eligible Expenses are covered at 100% of the billed charges and are subject to the benefit maximums as shown on your Schedule of Coverage.

You may have to submit claims for the services provided. You will be responsible for:

- Limited or non-covered services, and
- Any amounts in excess of the applicable Calendar Year maximums shown on your Schedule of Coverage

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.
Website	www.bcbstx.com	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

- Distribute claim forms,
- Order additional or replacement Identification Cards,
- Answer your questions on claims, and
- Provide information on the features of the Plan.

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.

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 and is in a class eligible to be covered under the Plan. The Eligibility Date is the date the Employee completes the Waiting Period, if any, for coverage.

Employee Eligibility

Any person eligible under this Plan and covered by the Employer's previous 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.

Effective Dates of Coverage

In order for an Employee's coverage to take effect, the Employee must submit written enrollment for coverage for himself. 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 Claim Administrator through the Plan Administrator.

If you apply for coverage and make the required contributions and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claim 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 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 Claim 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.

Group Enrollment Application/Change Form

Use this form to...

- Notify the Plan of a change to your name,
- Cancel all or a portion of your coverage, and
- Notify the Plan of all changes in your address.

You may obtain this form from your Employer, or by calling the Claim Administrator's Customer Service Helpline telephone number shown in this Benefit Booklet or on your Identification Card, or by accessing the BCBSTX website. After you have completed the form, return it to your Employer.

Identification Card

The Identification Card tells Providers that you are entitled to benefits under the 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 Claim Administrator.
- ***Your group number.*** This is the number assigned to identify your Employer's Health Benefit Plan with the Claim Administrator.
- ***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.

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

1. The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you 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 Provider of your choice;
 - d. Recoupment from you 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.

CLAIM FILING AND APPEALS PROCEDURES

CLAIM FILING PROCEDURES

Filing of Claims Required

Claim Forms

When the Claim 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 Claim 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

You will need to submit claims to the Claim 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. 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 Claim Forms

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

Who Receives Payment

Benefit payments will be made directly to you when you make proper claim for Eligible Expenses to the Claim Administrator. 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.

The Claim 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 Claim Administrator within three (3) months of the date you receive the services or supplies. Claims submitted and received by the Claim Administrator after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Claim Administrator

A claim will be considered received by the Claim Administrator for processing upon actual delivery to the Administrative Office of the Claim 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 Claim Administrator may contact either you for the additional information.

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

Interpretation of Employer's Plan Provisions

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

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

All powers to be exercised by the Claim 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.

BENEFITS PROVIDED

Inpatient Hospital Expenses

The Plan provides coverage for Inpatient Hospital Expenses. Benefits will be allowed at the daily allowance amount and will be limited to the maximum benefit days as shown on your Schedule of Coverage.

The Plan is responsible for the daily allowance amount for each covered day of your Inpatient Hospital Admission. Any remaining unpaid Inpatient Hospital Expense, including any expenses of the maximums shown on your Schedule of Coverage, is your obligation to pay.

Outpatient Surgical Expenses

The Plan provides coverage for Outpatient Surgical Expenses. Benefits will be determined as shown on your Schedule of Coverage up to the maximum benefit amount for each surgical procedure.

The Plan is responsible for the amount per procedure shown on your Schedule of Coverage. Any remaining unpaid Outpatient Surgical Expenses in excess of the maximum benefit amount for each surgical procedure is your obligation to pay.

Chemotherapy and Radiation Therapy

The Plan provides benefits for Chemotherapy and Radiation Therapy. Benefits will be determined up to the Calendar Year maximum shown on your Schedule of Coverage.

The benefit percentages of your total eligible Chemotherapy and Radiation Therapy expenses shown under “Chemotherapy and Radiation Therapy” on your Schedule of Coverage are the Plan’s obligation. Any remaining unpaid Chemotherapy and Radiation Therapy expenses in excess of the Calendar Year maximum is your obligation to pay.

Preventive Care

The Plan provides benefits for Preventive Care. Benefits will be determined up to the Calendar Year maximum shown on your Schedule of Coverage.

The benefit percentages of your total eligible Preventive Care expenses shown under “Preventive Care” on your Schedule of Coverage are the Plan’s obligation. Any remaining unpaid Preventive Care expenses in excess of the Calendar Year maximum is your obligation to pay.

Preventive Care includes:

1. Routine physical examinations;
2. Routine blood screening;
3. Routine mammograms;
4. Pap smear tests;
5. Routine vision examinations; and
6. Routine hearing examinations.

Prescription Drugs

The Plan provides benefits for prescription drugs received from a retail pharmacy. Benefits will be determined up to the Calendar Year maximum shown on your Schedule of Coverage. Any remaining unpaid prescription drug expenses in excess of the Calendar Year maximum is your obligation to pay.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

1. Any services or supplies which are not 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 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.
4. 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.
5. 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.
6. Any services or supplies provided by a person who is related to the Participant by blood or marriage.
7. 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.
8. Any charges:
 - For completion of any insurance forms; or
 - For acquisition of medical records.
9. 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.
10. Any benefits in excess of any specified dollar, day/visit, or Calendar Year maximums.
11. 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.
12. Any non-prescription drugs.
13. 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.

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

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

Effective Date means the date the coverage for a Participant actually begins. It may be different from the Eligibility Date.

Eligible Expenses mean either Inpatient Hospital Expenses, Outpatient Surgical Expenses, Chemotherapy and Radiation Therapy, or Preventive Care, as described in the **BENEFITS PROVIDED** section of this Benefit Booklet.

Eligibility Date means the date the Participant satisfies the definition of “Employee” and is in a class eligible for coverage under the Plan as described in the **WHO GETS BENEFITS** section of this Benefit Booklet.

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.

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 Claim 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 Claim 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.

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 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 Claim 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 Claim Administrator of the Plan indicating pertinent information applicable to his coverage.

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 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.

Open Enrollment Period means the 31-day period during which Employees 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 in Psychology
 - c. Doctor of Chiropractic
 - d. Doctor of Dentistry
 - e. Doctor of Optometry
 - f. Doctor of Podiatry
 - g. Licensed Audiologist
 - h. Licensed Chemical Dependency Counselor
 - i. Licensed Clinical Social Worker
 - j. Licensed Dietitian
 - k. Licensed Marriage and Family Therapist
 - l. Licensed Occupational Therapist
 - m. Licensed Physical Therapist
 - n. Licensed Professional Counselor
 - o. Licensed Speech–Language Pathologist
 - p. Licensed Surgical Assistant
 - q. Midwife
 - r. Nurse First Assistant
 - s. Physician Assistant
 - t. 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.

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

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 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 January 1 of each Calendar Year.

Plan Effective Date means January 1 of each Calendar Year.

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.

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

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 Claim Administrator.

Amendments

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

Claims Liability

BCBSTX, in its role as Claim 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 Claim 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 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. The Claim Administrator does not furnish services or supplies but only makes payment for Eligible Expenses incurred by Participants. The Claim Administrator is not liable for any act or omission by any health care Provider. The Claim Administrator does not have any responsibility for a health care Provider's failure or refusal to provide services or supplies to you. 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 Claim Administrator and/or other contracting Providers are independent contractors with respect to each other. The Claim Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claim 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 Claim Administrator pays benefits for Eligible Expenses incurred by you 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 Claim Administrator may deduct any refund due it from any future benefit payment.

Termination of Coverage

The Claim Administrator for the Plan is not required to give you prior notice of termination of coverage. The Claim 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 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.

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

Termination of the Group

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

AMENDMENTS

BENEFIT BOOKLET NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of Your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or Texas law, in the event of a conflict between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to You and Your mean any member, including Participant and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), You may be able to continue coverage for that Provider's covered services at the in-network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for Your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester

of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Benefit Booklet and this Amendment, those terms will apply only to their use in the Benefit Booklet or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or an Independent Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or an Independent Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
 1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
 2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
 3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

“Non-Participating Emergency Facility” means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an Independent Freestanding Emergency Department that does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

“Participating Provider” means, for purposes of this Amendment only, with respect to a covered service, a physician or other health care provider who has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

“Participating Facility” means, for purposes of this Amendment only, with respect to covered service, a hospital or ambulatory surgical center that has a contractual relationship with BCBSTX setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network benefits under the subject Plan.

“Qualifying Payment Amount” means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

“Recognized Amount” means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

- a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections (“Included Services”) are listed below.
 - Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
 - Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless You give written consent and give up balance billing protections).

- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles, Copayment Amounts, and Co-Share Amount, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or Out-of-Pocket Maximum, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost-share. You cannot be balance billed for these Emergency Services unless You give written consent and give up Your protections not to be balance billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill You is Your Plan's in-network cost-share requirements. When You receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed. If You get other services at Participating Facilities, Non-Participating Providers can't balance bill You unless You give written consent and give up Your protections.

If Your Plan includes Air Ambulance Services as a covered service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill You is Your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to Your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

NOTICES

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.

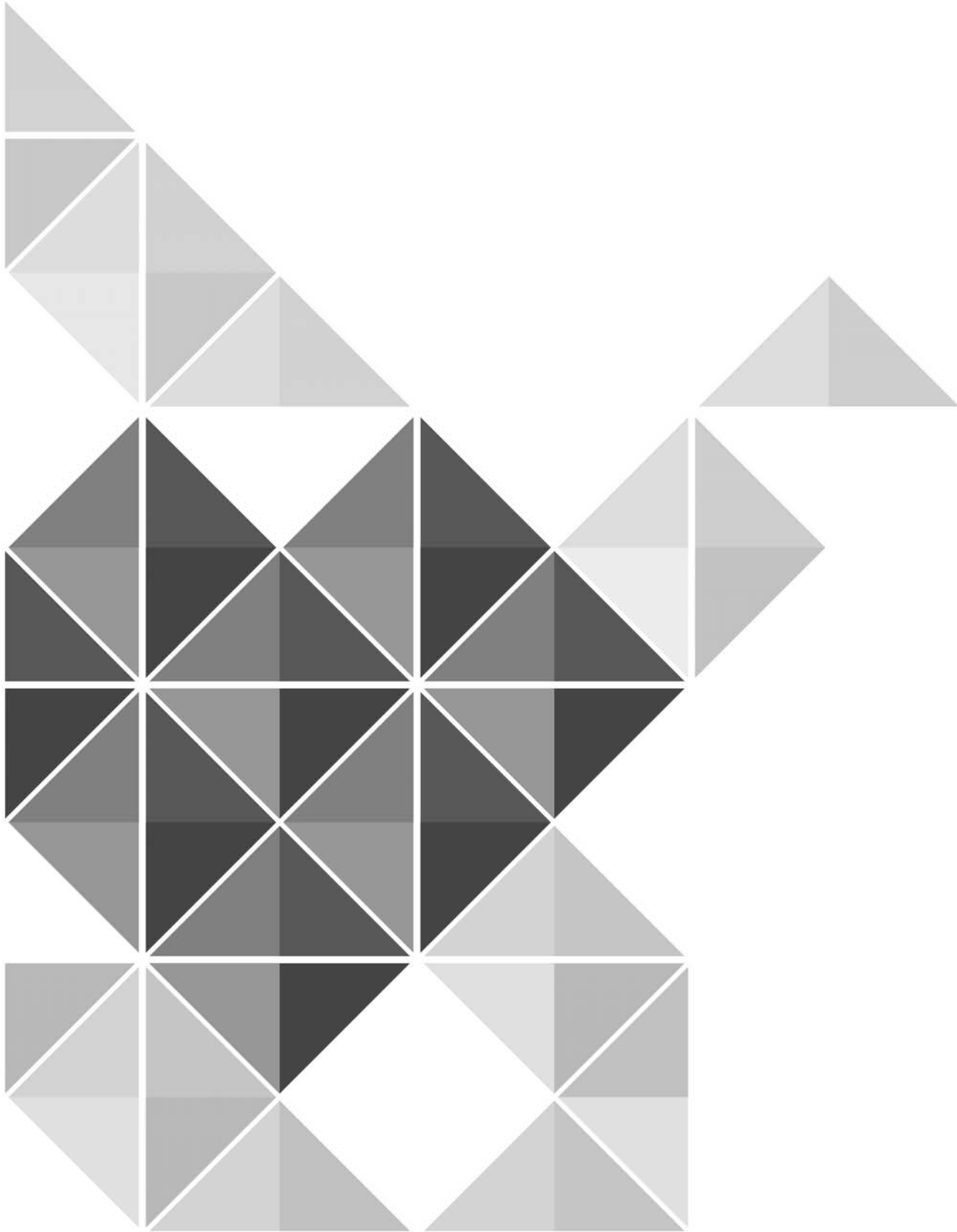
PLAN CONTACT INFORMATION

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

Administered by:



**BlueCross BlueShield
of Texas**



bcbstx.com

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