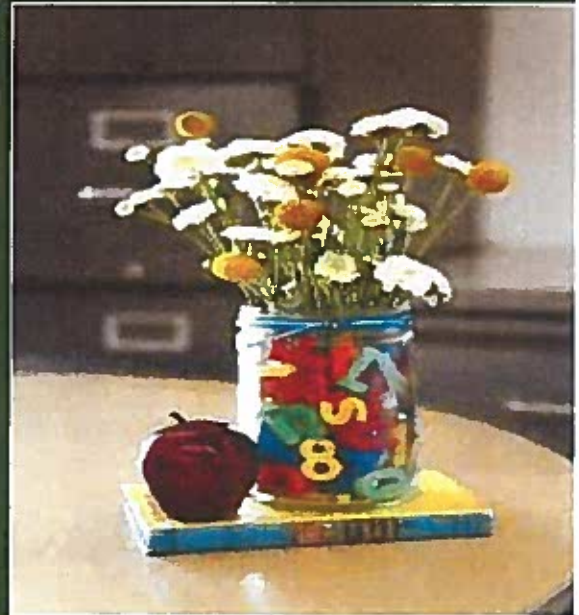




2013-2014

TRS Compatibility Report



Terrell County Independent School District
2013-2014

SECTION	TITLE
Section I	Group Health Coverage Contract
Section II	Summary of Benefits
Section III	Premium Rate Sheet
Section IV	Enrollment Data
Section V	Comparability Report Form
Section VI	Compliance Statement

Section I

Group Health Coverage Contract



**BlueCross BlueShield
of Texas**

GROUP ADMINISTRATION DOCUMENT

WHEREAS, the "Contractholder" or "Employer" has purchased health care insurance from **Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation** (herein called BCBSTX or Carrier) Richardson, Dallas County, Texas, and has executed a Benefit Program Application; and

WHEREAS, the Benefit Program Application establishes the Contract Effective Date and the Account Number(s) of the Contractholder under this Contract; and

WHEREAS, BCBSTX hereby accepts such Benefit Program Application, subject to the financial and administrative relationships and responsibilities of both parties for the purpose of providing health care benefits on behalf of eligible Participants;

NOW THEREFORE, this Contract is issued in consideration of the Benefit Program Application and of the timely payment of premiums as required herein. This Contract shall become effective on the Contract Effective Date specified on the Benefit Program Application and will be continued in effect by the payment of premiums at the rates determined by the Carrier in accordance with the provisions in Premiums until terminated as provided in Termination of Coverage.

IN WITNESS WHEREOF, the Carrier has caused this Contract to be executed at its Administrative Office in Richardson, Texas.

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

President of Blue Cross and Blue Shield of Texas

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

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

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INTRODUCTION

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

1. This Group Administration Document;
2. The Benefit Program Application;
3. The Benefit Booklet(s); and
4. Any other applications, Schedule(s) of Coverage, riders, enclosures, addenda, exhibits, and amendments to any of them.

This Group Administration Document contains those aspects of the Contract more specifically applicable to the Employer. The Benefit Booklet contains information more specifically applicable to Participants. In the event of any conflict between any components of the health care benefit program, this Group Administration Document prevails.

I. DEFINITIONS

Additional definitions applicable to the Contract are contained in the Benefit Booklet and the Benefit Program Application. As used throughout the Contract:

Benefit Booklet means the document issued by BCBSTX to the Employer, via an electronic file or access to an electronic file, if applicable, as specified on the Benefit Program Application, for delivery to each Employee. The Benefit Booklet describes the health care benefit program purchased by the Employer, including benefits, limitations, exclusions and requirements of the Contract, and being administered by BCBSTX pursuant to the Contract.

Benefit Program Application means the initial application for the Contract. When fully executed, the Benefit Program Application shall become a part of the Contract.

Certificate of Creditable Coverage means a document which is generated for Participants terminating coverage under BCBSTX. The certificate is provided to Participants as evidence for credit of health coverage held under BCBSTX during the term of this Contract.

Contract means this Group Administration Document between the Contractholder and BCBSTX; the Benefit Booklet(s); the Benefit Program Application; and any other applications, Schedule(s) of Coverage, riders, enclosures, addenda, exhibits, and amendment to any of them.

Contract Anniversary Date means the month, day, and year specified in the Benefit Program Application and the corresponding date in each year thereafter for as long as the Contract is in force.

Contract Effective Date means the month, day and year specified in the Benefit Program Application on which coverage for the Large Employer's Contract with BCBSTX commences.

Contractholder or Employer means the Large Employer which has executed the Benefit Program Application for the Contract.

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

- A. For a new Employee, including any eligible Dependents to be covered, the date such Employee completes the number of days of continuous employment with the Large Employer (Waiting Period) as specified in the Benefit Program Application, or
- B. For a new Dependent of an Employee already having coverage under this Contract, the date the Employee acquired such Dependent; or
- C. If elected by the Employer on the Benefit Program Application and if this Contract replaces prior coverage of the Large Employer, for each Employee who was covered under the Large Employer's Health Benefit Plan immediately prior to the Contract Effective Date of this coverage, the Waiting Period is waived on initial enrollment.

Employee means an individual employed by a Large Employer.

- A. For purposes of this plan, the term *Employee* will also include those individuals who are no longer an Employee of the Large Employer, but who are participants covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the *Texas Insurance Code*.
- B. If specified as eligible on the Benefit Program Application, Employees who have retired under the Large Employer's established procedures, whether by either individual selection by the Large Employer or the Employee to be included in a retiree classification, may continue coverage under this Contract.

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

Medicare means the programs established by Title XVIII of the Social Security Act (42 U.S.C. section 1395 et seq.).

Medicare Secondary Payer ("MSP") means those provisions of the Social Security Act set forth in 42 U.S.C. section 1395 y (b), and the implementing regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain employers may offer group health care coverage to Medicare-eligible Employees, their spouses and, in some cases, Dependent children.

Plan Service Area (Applicable only if Managed Health Care coverage is purchased by the Employer) means the geographical area(s), used to determine eligibility for Managed Health Care Plan benefits.

- A. The geographical area(s) documented in the attached **Exhibit A. - Plan Service Area Listing**, shall be the Plan Service Area for Participants enrolled in the Managed Health Care coverage under this Contract.
- B. If the Employee resides in the Plan Service Area, Managed Health Care Plan coverage will be available for him and all his Dependents. An Employee residing outside the Plan Service Area may elect Managed Health Care Plan coverage for himself and all of his Dependents if his place of employment is located within the Plan Service Area.
- C. An Employee residing outside of the Plan Service Area will be covered by Traditional Medical Benefit coverage that will be issued under a separate contract, when necessary.
- D. Only Network Providers can provide or arrange for In-Network services under the Managed Health Care Plan provisions.

- E. BCBSTX shall annually furnish Provider Network directories to each Employee enrolled under Managed Health Care coverage. These directories list names, locations, and other information specific to those Network Physicians, Hospitals, and other health care providers and facilities in the Plan Service Area.

Service Mark means the names BLUE CROSS and/or BLUE SHIELD and the associated logos, along with all related or derivative marks including, but not limited to, any Blue Cross or Blue Shield formulations or designs

II. ELIGIBILITY FOR COVERAGE; EFFECTIVE DATES; RECORDS OF PARTICIPANT ELIGIBILITY AND ADJUSTMENTS

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

B. Application for Coverage

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

C. Effective Dates - Timely Application

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

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

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

D. Annual Election of Coverage

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

E. Records of Participant Eligibility and Adjustments

The Employer must furnish to BCBSTX data as may be required by BCBSTX regarding the Participants who are to be covered under the Contract. Such data may include, without limitation, a list of Participants who are to be covered under the Contract, completed enrollment application forms, information required by BCBSTX to identify dual coverage situations which are subject to Medicare Secondary Payer ("MSP") laws and information required for Certificate(s) of Creditable Coverage that will be issued by BCBSTX. It is the Employer's obligation to notify BCBSTX no later than thirty-one (31) days after the effective date of any

change in a Participant's status under the Contract. All such notifications by the Employer to BCBSTX (including, but not limited to, forms and tapes) must be furnished in a format approved by BCBSTX and must include all information reasonably required by BCBSTX to effect such changes. Minor clerical errors in keeping or reporting data relative to coverage under the Contract will not invalidate coverage which would otherwise be validly in force or continue coverage which would otherwise validly terminate. Examples of such minor clerical errors include, but are not limited to, errors appearing in an individual's name, address, or birth date as well as typographical errors. The term "minor clerical errors" as used herein does not include Employer errors which may materially affect an individual's coverage under the Contract. It is further understood and agreed that the Employer is liable for any substantive error made by the Employer in keeping or reporting data which may materially affect an individual's coverage under the Contract and for any benefits paid for a terminated Participant if the Employer had not timely notified BCBSTX of such Participant's termination.

During the term of the Contract and within one hundred eighty (180) days after the termination of the Contract, BCBSTX may, upon at least thirty (30) days prior written notice to the Employer, conduct reasonable audits of the Employer's membership records with respect to eligibility.

The Employer hereby agrees to indemnify and hold harmless BCBSTX and its employees and agents for any loss, damage, expense (including, but not limited to, reasonable attorneys' fees and costs) or liability that may arise from or in connection with untimely and/or inaccurate data provided by the Employer to BCBSTX or data furnished by the Employer to BCBSTX in a format not approved by BCBSTX.

III. PREMIUMS

- A. The premium rates initially effective shall be shown in the new group rates letter ("Letter") or the renewal exhibit ("Exhibit") and continuance of the coverage shall be contingent upon payment of the premiums by the Employer at the Administrative Office of the Carrier in Richardson, Texas, in accordance with the following provisions: (1) the first premium is due on the Contract Effective Date; (2) subsequent premiums are, during the continuance of this Contract, payable in advance. Any adjustments to premiums, prorated premium, or arrearage caused by either an effective date prior to a regular premium billing or a retroactive effective date shall be payable immediately upon receipt by the Employer of a billing by the Carrier. The Carrier may refuse to accept any payment which does not represent a total premium, or which is late. Any acceptance by the Carrier of a late or partial premium payment shall not be deemed a waiver of this section A in the event of any future failure of the Employer to make a timely or total payment of premium.
- B. If any portion of the premiums due under this Contract is required to be paid by any covered Employee or Dependent, the Employer agrees to collect such amounts due on the Employee's behalf as their agent, and to pay over such funds to the Carrier as part of the total premium due. The Employer shall not act as an agent of the Carrier with regard to such collections, and no premium will be considered to have been paid until actually received and accepted by the Carrier.
- C. Premiums may be paid on a monthly, quarterly, semiannual, or annual basis as the Employer may elect, but without discount.
- D. The premium to be paid shall be determined by multiplying the number of Employees covered for each classification by the rate then applicable for that classification, and totaling the extensions thus obtained.

For Dependents whose coverage becomes effective in accordance with provisions described in Article II of this Contract and the **WHO GETS BENEFITS** section of the Benefit Booklet on other than the first day of a Contract Month and on a date other than the Employee's Effective Date, no premium shall be due for any portion of the Contract Month in which the coverage becomes effective;

For all other Participants whose coverage becomes effective in accordance with provisions described in Article II of this Contract and the **WHO GETS BENEFITS** section of the Benefit Booklet on other than the first day of a Contract Month, premium shall be prorated for the portion of the Contract Month in which the coverage becomes effective.

If elected by the Employer on the Benefit Program Application, premiums will be billed for the entire month for Participants with effective dates on the first (1st) through the fifteenth (15th) day of the month. Premiums will not be billed for the month when the Participant's effective date falls on the sixteenth (16th) day through the end of the month.

- E. This Contract shall be nonassessable and does not share in the earnings of the Carrier. The Carrier shall have the right to change the premium rates on any premium due date occurring after the period of time for which the premium rates are to be in effect as indicated, in the new group rates letter ("Letter") or the renewal exhibit ("Exhibit") or any amendment, revision, or replacement of such Rates section made in writing.

Any such change shall be made uniformly applicable to all Employees within any subgroup or other classification under this Contract.

Notwithstanding the foregoing paragraphs of this section E, premium rates may be changed at any time by mutual agreement between the Carrier and the Employer.

- F. The Carrier reserves the right to change the premium rates:

1. On any Contract Anniversary Date, provided not less than sixty (60) days before the date on which a premium rate increase takes effect, BCBSTX shall give prior written notice to the Employer of the amount of such increase and the date on which the increase is to take effect; or
2. If a substantial change occurs in the number or composition of Employees covered, which results from:
 - a. The addition of an alternative Health Benefit Plan such as a health maintenance organization, an alternative prescription drug plan, or preferred Provider organization; or
 - b. A change in the benefit specifications provided under this Contract; or
 - c. A change in contribution level or other consideration paid by the Employer; or
 - d. The opening or closing of any offices or facilities or any layoffs in the workforce by the Employer; or
 - e. The sale, acquisition, or merger of the Employer's company by or with another company; or
 - f. The purchase or acquisition of another company by the Employer's company; or
 - g. Filing for bankruptcy or reorganization under state or federal law by the Employer.
 - h. A substantial change will be deemed to have occurred when the number of Employees covered changes by:
 1. 10% or more over a 30-day period; or
 2. 25% or more over a 90-day period; or
 3. Falling below the specifications shown in the Minimum Enrollment Requirements provision of the Benefit Program Application for a period of six consecutive months.

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

- G. Any premium amounts due shall automatically be increased by the amount of any taxes imposed, increased, or adjudged due by any lawful authority on or after the Contract Effective Date which the Carrier is required to pay or remit, whether relating to fees, services, benefits, payments, or any other aspect of this Contract.
- H. A premium delay period of 30, 60, or 90 days shall be allowed for the payment of each premium if any such premium delay period is specified on the Benefit Program Application, except the first. Within ten days from the first of each Contract Month, the Employer will notify the Carrier of all deletions in enrollment to be effective the first of such Contract Month. Claims for benefits provided by the Contract for services and supplies incurred by Participants during the premium delay period shall continue to be processed.

The reporting of a Participant as covered shall obligate the Employer for payment of that Participant's premium for that Contract Month.

If any premium is not paid by the end of any premium delay period, this Contract shall terminate at the end of such premium delay period except that the Contract may terminate at an earlier date as provided in **Termination of Coverage**, section A. If the Contract terminates during or at the end of the premium delay period, the Employer shall be liable to the Carrier for payment of a pro rata premium for the time the Contract was in force.

IV. TERMINATION OF COVERAGE

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

- A. The coverage of all Participants hereunder shall automatically terminate when this Contract is terminated in any manner, as follows:
 - 1. By cancellation on any premium due date, at the request in writing of the Employer furnished to the Carrier at its Administrative Office, not less than 30 days in advance;
 - 2. If this Contract is replaced by another Blue Cross and Blue Shield of Texas contract;
 - 3. By default in premium payment, as required in Article III, on the last day of the last period for which the entire group premium is paid; provided, however, any failure of the Carrier to terminate coverage shall not be deemed a waiver of this subsection in the event of any future default in premium payment;
 - 4. The Employer commits fraud or intentional misrepresentation of a material fact;
 - 5. No enrollee in connection with the Plan resides or works in the service area of the Carrier or in the area for which the Carrier is authorized to do business;
 - 6. Upon non-renewal, in the event of failure to maintain the minimum enrollment requirements shown in the Benefit Program Application, for a period of six consecutive months; or
 - 7. If the Employer has not complied with the terms of the health benefit plan relating to premium contribution, group size, or participation requirements.

B. The coverage of any Employee and his Dependents included hereunder shall terminate:

1. Subject to the provisions in item B (4), below, on the last day of the last period for which his portion of the group premium is paid to the Carrier. The Employer may terminate the coverage of any Employee on the last day of any Contract Month for which premiums for such Employee have been received by the Carrier and any premiums for such Employee that are applicable to succeeding Contract Months will be refunded by the Carrier to the Employer upon request, if the Employer has paid premium on a quarterly, semiannual, or annual basis.
2. The effective date of an amendment to this Contract, issued at the direction of the Employer, that terminates the coverage of any class of Employees to which he belongs;
3. Subject to the provisions in item B (4), below, on the last day of the Contract Month during which the Employee ceases to be an Employee as defined in Article I of this Contract and is not eligible to retain Employee status under any employer benefit plan(s) created in accordance with the Employer's established procedures whereby individual selection by the Employer or the Employee to be included under such plan(s) is precluded.
4. As provided under state law, the Employer will be liable for the individual's premiums from the time the individual is no longer part of the group eligible for coverage under the Contract until the end of the Contract Month in which the Employer notifies BCBSTX that the individual is no longer part of the group eligible for coverage under the Contract and the individual will remain covered under the Contract until the end of that period. Notwithstanding the foregoing, if an individual ceases to be eligible within the last (7) calendar days of a Contract Month and the Employer notifies BCBSTX of such loss of eligibility within the first three (3) business days of the subsequent Contract Month, the individual's coverage shall terminate on the last day of the Contract Month in which the individual lost eligibility.

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

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

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

D. Under no circumstances shall the Carrier be obligated to notify any Participant of the termination of this Contract or of his coverage hereunder.

E. Notwithstanding the above provisions of this Article IV, if the Employer is paying an Employee's premiums in whole or in part pursuant to the terms of a collective bargaining agreement and in the event of cessation of work as the result of a labor dispute by its Employees who are members of the bargaining unit, coverage under this Contract for such Employees and their Dependents hereunder shall terminate on the last day of the Contract Month in which such cessation of work began subject to the provisions in B(4), above; except that coverage under this Contract may be continued for such Employee and Dependents for a period of up to six additional Contract Months, provided that for each such additional Contract Month:

1. Coverage of at least 75% of the Employees, who are members of the bargaining unit and who cease working due to the labor dispute, is maintained; and
2. A single payment for the premiums due from such Employees is remitted for such premium payment.

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

V. REPLACEMENT OF COVERAGE

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

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

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

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

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

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

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

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

1. If applicable, any expenses incurred by a Participant in the same Calendar Year preceding the Contract Effective Date, which will qualify as Eligible Expenses under this Contract, and which were applied toward satisfaction of the Calendar Year Deductible of the prior coverage, will be applied toward satisfaction of the Calendar Year Deductible of this Contract, provided the Participant submits proof of such Eligible Expenses satisfactory to BCBSTX in accordance with BCBSTX's procedures.
2. If applicable, any Coinsurance Amounts for expenses incurred by a Participant in the same Calendar Year preceding the Contract Effective Date, will be credited toward the Coinsurance Stop-Loss Amount of this Contract, provided the Participant submits proof of such Coinsurance Amounts satisfactory to BCBSTX in accordance with BCBSTX's procedures.
3. Benefits are not available for expenses incurred prior to the Contract Effective Date or for any services or supplies provided during the course of a Hospital Admission or an admission in a Facility Other Provider which were incurred prior to the Contract Effective Date.
4. Benefits will be available for Eligible Expenses incurred on and after the Contract Effective Date.
5. In no event will coverage be continued beyond the date it would otherwise terminate under the terms of this Contract.

VI. GENERAL PROVISIONS

- A. **Agency Relationships:** Nothing in the Contract shall be construed to constitute the Employer as an agent of BCBSTX. The Employer is the agent of the Participants.
- B. **Applicable Law:** This Contract is issued in Texas. All disputes arising under this Contract between BCBSTX and the Contractholder shall be resolved in Texas under the laws of the state of Texas.
- C. **Certificate:** The Carrier will issue to the Employer for delivery to each covered Employee a certificate (herein called Benefit Booklet) setting forth a statement of the essential features of the insurance coverage of such Employee or Participant, and to whom the benefits are payable.
- D. **Certificate of Creditable Coverage:** BCBSTX shall issue a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under BCBSTX during the term of the Contract and information provided to BCBSTX by the Employer.
- E. **Compliance with Laws and Regulations:** BCBSTX and Employer will comply with applicable state and federal laws and regulations regarding confidentiality or privacy of records and other information and to cooperate to ensure such compliance.
- F. **Coverage Data:** The Employer shall furnish the Carrier all information needed to effect coverage of Employees and Dependents hereunder and termination and changes in such coverage on a timely basis.
- G. **Disclaimer:** The Carrier shall not be liable for any act or omission by any Hospital, Physician, or Other Provider, their agents or employees, in caring for a Participant receiving services covered under this Contract, and no responsibility attaches hereunder for inability of any Hospital, Physician, or Other Provider to furnish accommodations or services. Benefits are subject to the rules and regulations of the Hospital, facility or other institution selected by the Participant, and are available only for sickness or injury acceptable to such Hospital, facility, or other institution.

II. Discontinuance of A Particular Product: BCBSTX may discontinue the Employer's benefit plan product under the Contract if BCBSTX:

1. Provides ninety (90) days advance notice to the Employer and Participants;
2. Offers the Employer an option to purchase other coverage offered to other employers of similar circumstance, including, but not limited to, employer size; and
3. Acts uniformly without regard to the claims experience of the Employer or the health status of any existing, new or potentially new Participants.

I. Electronic Exchange of Data: In the event the Employer and Carrier exchange data and information electronically, the Employer agrees to transfer on a timely basis all required data to the Carrier via electronic transmission on the intranet and/or internet or otherwise, in the format specified by the Carrier, a copy of which shall be furnished to the Employer upon written request to the Carrier. The Employer authorizes the Carrier to submit such data and information in the specified electronic format. In the event the Employer is unable or unwilling to transfer data in the specified electronic format, the Carrier is under no obligation to receive or transmit data in any other format unless required by law to do so. In the event garbled or intercepted transmissions occur, Carrier and the Employer agree to redirect the information via another mutually agreeable means.

The Employer consents to receive, via an electronic file or access to an electronic file, a Benefit Booklet provided by the Carrier to the Employer for delivery to each Employee.

The Employer further acknowledges and agrees that it is responsible for providing Employees access, via the intranet, internet, paper copy or otherwise, to the most current version of any electronic file provided to the Employer by the Carrier. The Employer agrees to provide a paper copy of the same to an Employee who has not agreed to accept the Benefit Booklet electronically. In addition, in all instances, the electronic file of the most current document issued to the Employer by the Carrier for use by the Employer is the legal document used to administer the Contract and will prevail in the event of any conflict between such electronic file and any other electronic or paper file. The Employer is solely responsible for, and holds the Carrier harmless from, any and all claims for loss, liability or damages arising from the use or posting of the electronic file on the intranet and/or internet.

- J. Employer Notification To Participants:** It is the responsibility of the Employer to notify all Participants in the event of the Employer's uniform modification of coverage, uniform termination of coverage or discontinuance of coverage in a market segment.
- K. Entire Contract:** This Group Administration Document and its Benefit Program Application, any applications, the Benefit Booklet(s), Schedule(s) of Coverage, and any exhibits, riders, enclosures, addenda and amendments to any, shall constitute the entire Contract; and, in the absence of fraud, all statements made by the Employer or by the person insured shall be deemed representations and not warranties. No statement shall be used in any contest or in defense of a claim hereunder unless a copy of the instrument containing the statement is or has been furnished to such person, or in the event of death or incapacity of the insured person, to the individual's beneficiary or personal representative. No change in this Contract shall be valid until approved by an executive officer of BCBSTX and unless such approval is attached by amendment, rider or otherwise provided in writing in this document. No agent has the authority to change this Contract or to waive any of its provisions. The issuance of this Group Administration Document supersedes all previous contracts or policies between the Employer and BCBSTX which are in force on the Contract Effective Date as indicated on the Benefit Program Application.

L. **ERISA:** This provision applies to any Contract which implements any employee welfare benefit plan as defined by Section 3 (2) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

1. The Employer (or (i) if the Employer is a trust, the grantor of such trust or (ii) if the Employer is an association, each member of such association who pays premiums under such Contract) has established and as sponsor, maintains pursuant to other written documents, a health benefit program ("Employer's ERISA Health Benefit Program") through the purchase of insurance for the benefit of its eligible Participants, which Employer's ERISA Health Benefit Program is an "employee welfare benefit plan" within the meaning of ERISA. Notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any Employer member, if the Employer is an association), the Employer agrees that no allocation or delegation or any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (or any Employer member, if the Employer is an association) is effective with respect to or accepted by BCBSTX except to the extent specifically provided and accepted in the Contract or as otherwise accepted in writing by BCBSTX. The administrator under ERISA for an Employer's ERISA Health Benefit Program is the Employer or such other persons (other than BCBSTX) appointed by the Employer (or (i) if the Employer is a trust, by the grantor of such trust or (ii) if the Employer is an association, by each member of such association who pays premiums under such Contract). Nothing in an Employer's ERISA Health Benefit Program will affect the obligations of BCBSTX with respect to this Contract. BCBSTX will not be required to examine the provisions of an Employer's ERISA Health Benefit Program or any related trust agreement, or any modification, amendment or supplement thereto.
2. The Contract is a guaranteed benefit policy (as defined in Section 401 (b) (2) of ERISA). The Contract is an asset of the Employer. No assets of BCBSTX or amounts which have been paid to BCBSTX under the Contract are assets of or under Employer's ERISA Health Benefit Program.

M. **Incontestability:** This Contract shall be incontestable after it has been in force for two years from date of its issue except for nonpayment of premiums. In the absence of fraud, no statement made by any person covered under this Contract relating to his insurability shall be used in contesting the validity of the coverage with respect to which such statement was made after such coverage has been in force prior to the contest for a period of two years during such person's lifetime unless it is contained in a written instrument signed by him; provided, however, this provision shall not limit any defense of such claim based on provisions in the Contract: (1) relating to eligibility for coverage; (2) relating to coordination of benefits; or (3) limiting the amounts of recovery from all sources to no more than 100% of the total actual losses incurred.

N. **Information and Medical Records:**

1. All claim information, including, but not limited to, medical records, received by BCBSTX in the performance of its duties hereunder will be kept confidential by BCBSTX and except for reasonable necessary use by BCBSTX in connection with the performance of its duties hereunder, BCBSTX shall not disclose such confidential claim information without the authorization of the Participant or as otherwise required or permitted by applicable law.
2. BCBSTX may release to the Employer claim information regarding the provision of Covered Medical Services to Participants and copies of records to the extent required or permitted by applicable law, including but not limited to HIPAA. Any information so obtained by the Employer shall be kept confidential, as required by applicable law.
3. The Employer acknowledges that each Participant agrees it is the Participant's responsibility to ensure that any Provider, Blue Cross and Blue Shield Plan, insurance company, employee benefit association, governmental body or program, or any other person or entity having knowledge of or records relating to (1) any illness or injury for which a claim or claims for benefits are made under the Contract, (2) any medical history which might be pertinent to such illness, injury, claim or claims, or (3) any benefits or indemnity on account of such illness or injury or on account of any previous illness or injury which may

be pertinent to such claim or claims, furnish to BCBSTX, or its agent, and agrees that any such Provider, person or other entity may furnish to BCBSTX or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, injury, claim or claims. In addition, BCBSTX may furnish similar information and records (or copies of records) to Other Providers, Blue Cross and Blue Shield Plans, insurance companies, governmental bodies or other entities providing insurance-type benefits requesting the same. It is also the Participant's responsibility to furnish to the Employer and/or BCBSTX information regarding the Participant's becoming eligible for Medicare, termination of Medicare eligibility or any change in Medicare eligibility status.

- O. **Legal Actions:** No action at law or in equity shall be brought to recover on this Contract prior to the expiration of 60 days after written Proof of Loss has been filed in accordance with the requirements herein and no such action shall be brought at all unless brought within three years from the expiration of the time within which written Proof of Loss is required to be furnished by this Contract.
- P. **Medicare/Primary Carrier Determinations:** Any exclusions of benefits in this Contract for services or supplies for which benefits are paid or payable under governmental programs and the definition of "Plan" in the **Coordination of Benefits** section of the Benefit Booklet shall not be applicable to Medicare Part A and Part B benefits for those Employees who the Employer determines are Employees for whom the Employer's benefit plan is required to be primary to Medicare by the Age Discrimination in Employment Act (ADEA) for the period of time such primary coverage is so required. This provision shall also be applicable to Dependent spouses of Employees so designated for the period of time, if any, that the spouse's coverage under the Employer's benefit plan is also required to be primary to Medicare.

The same exclusions and definition of "Plan" described above are not applicable to Medicare Part A and Part B benefits for Participants during the period specified by Medicare's regulations for secondary payer for treatment of end-stage renal disease due to kidney transplant or self-dialysis training of Medicare entitlement by reason of renal dialysis.

Q. **Medicare Secondary Payer ("MSP") Data Match**

In an effort to facilitate the processing of claims consistent with the requirements of the MSP statute, and to assist in meeting the statutory obligations, certain BlueCross and BlueShield Plans together with the Centers for Medicare and Medicaid Services ("CMS") formerly known as Health Care Financing Administration ("HCFA"), the federal government agency which administers Medicare, have developed a new enrollment and membership system. The system, also referred to as the "Data Match," is aimed at obtaining, in a timely and current fashion, information necessary for BCBSTX to identify dual coverage situations which fall within the MSP statute, and to determine whether primary or secondary payment should be made for a particular claim.

Under the system, BCBSTX will provide basic information to CMS about individuals enrolled in employer group health plans who are also covered by Medicare so that CMS can better detect dual coverage situations.

The Employer hereby authorizes and directs BCBSTX to disclose to CMS periodically, information pertaining to Medicare-eligible Participants under the Contract.

The Employer agrees that BCBSTX's ability to make accurate primary/secondary MSP determinations depends on the breadth and accuracy of BCBSTX's files concerning Participants. The Employer agrees to use best efforts in responding promptly and accurately to BCBSTX's requests for information and to require and facilitate its employees' cooperation in responding promptly and accurately to such requests.

Further, to assure the continuing accuracy of BCBSTX's files, the Employer agrees that it is the Employer's responsibility to notify BCBSTX promptly of any change in the size of the Employer's work force or status of its Employees that might effect the order of payment under the MSP statute, such as information regarding working-aged persons who retire and changes in the size of the Employer's work force that place it in, or take it out of, the scope of the MSP statute. If BCBSTX does not receive such information from the Employer, BCBSTX will assume that all relevant factors remain unchanged and will process claims accordingly. The

Employer acknowledges and agrees that BCBSTX will be using the information provided by the Employer and Participants to update BCBSTX's files, and will also forward this information to CMS so that CMS can revise its file to reflect relevant changes in primary/secondary status.

BCBSTX may, in its sole discretion, discontinue its participation in the Data Match system as described above. Nothing in this Contract shall be construed as obligating BCBSTX to continue its participation in the Data Match system.

Disclosure Statement: The Employer acknowledges that BCBSTX has furnished it with a copy of a pamphlet entitled "Information Regarding the Medicare Secondary Payer Statute" (also referred to as the "Disclosure Statement"), prepared by the BlueCross and BlueShield Association and reviewed by CMS, which administers Medicare.

- R. **Misstatement of Age:** In the event: (1) premiums are based on the Participant's age; and (2) the age of a Participant has been misstated, the premium rate for such person shall be determined according to the correct age as provided in this Contract and there shall be an equitable adjustment of premium rate made so that the Carrier shall be paid the premium rate at the true age of the Participant.
- S. **Misstatement of Enrollment:** In the event the Employer furnishes the Carrier with enrollment information and premiums for persons who are not eligible for coverage under this Contract as bona fide Employees or Dependents, the Carrier may retroactively or currently cancel the coverage of such persons after the Carrier learns of such persons' failure to qualify as Employees or Dependents. The Carrier shall return all premiums for the period for which coverage is canceled.
- T. **Notices:** Any notice given or required under the Contract or any individual certificate will be a written notice. If such notice is given to the Employer, it will be addressed to it at its office address stated in the Benefit Program Application. If such notice is given to BCBSTX, it should be addressed to BCBSTX at its office address stated in the Benefit Booklet. If such notice is given by BCBSTX to a Participant, it will be addressed to the Participant at the address as it appears on the records of BCBSTX or in the care of the Employer. The Employer and BCBSTX may, by written notice served on the other, indicate a new address for giving such notice.
- U. **Physical Examinations and Autopsy:** The Carrier shall have the right and opportunity to examine the person of the Participant for whom claim is made, when and so often as it may reasonably require during the pendency of a claim hereunder and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.
- V. **Proprietary Materials:** The Employer acknowledges that BCBSTX has developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which are proprietary information ("Business Proprietary Information"). The Employer shall not use or disclose to any third party Business Proprietary Information without prior written consent of BCBSTX. Neither party shall use the name, symbols, trademarks or service marks of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that BCBSTX may include the Employer in its list of clients.
- W. **Refund of Benefit Payments:** If and when the Carrier determines that benefit payments hereunder have been made erroneously but in good faith, the Carrier reserves the right to seek recovery of such benefit payments from the Participant, any other insurance company, or Provider of services to whom such payments were made. The Carrier reserves the right to offset subsequent benefit payments otherwise available by the amount of any such overpayments. Any refund of benefits will not be credited to the Employer's claims experience until actual recovery is made.

X. **Reinstatement:** If default be made in the premium payments for this Contract, the subsequent acceptance of such premium by the Carrier or any of its duly authorized agents shall fully reinstate the Contract. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of the Contract shall not be deemed a waiver of either the Employer's requirement of timely premium payment or the Carrier's right of termination for default in premium payment in the event of any future failure of the Employer to make timely premium payments.

Y. **Renewability of the Contract:** The Contract shall be renewable to all Participants except in the following instances:

1. Non-payment of required premiums;
2. A fraudulent act or practice or intentional misrepresentation by the Employer;
3. Noncompliance with BCBSTX's minimum participation requirements;
4. Noncompliance with BCBSTX's Employer contribution requirements;
5. Termination of the benefit plan in accordance with the "Discontinuance of A Particular Product" provision in this Contract;
6. Participant's movement outside the BCBSTX service area; or
7. Cessation of the Employer's membership in a bona fide association, but only if coverage is terminated uniformly without regard to the health status of any Participant.

Z. **Separate Financial Arrangements Regarding Prescription Drugs:**

1. **Separate Financial Arrangements with Participating Prescription Drug Providers:**

The Employer's experience account under the Contract, if any, the maximum amount of benefits payable by BCBSTX and all required Copayment, Deductible and Coinsurance Amounts under this Contract shall be calculated on the basis of the Provider's billed charge or the agreed upon cost between the Participating Prescription Drug Provider as defined below, and BCBSTX, whichever is less.

BCBSTX hereby informs the Employer and all Participants that it has contracts, either directly or indirectly, with prescription drug Providers ("Participating Prescription Drug Providers") for the provision of, and payment for, prescription drug services to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which BCBSTX is a party, including the Participants under the Contract, and that pursuant to BCBSTX's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, BCBSTX may receive discounts for prescription drugs dispensed to Participants under the Contract.

The Employer understands that BCBSTX may receive such discounts during the term of the Contract. Neither the Employer nor Participants hereunder are entitled to receive any portion of any such discounts in excess of any amount that may be reflected in the new group rates letter ("Letter") or the renewal exhibit ("Exhibit") as part of any experience rating refund, if applicable to this Contract, or otherwise.

2. **Separate Financial Arrangements with Pharmacy Benefit Managers:**

BCBSTX hereby informs the Employer and all Participants that it owns a significant portion of the equity of Prime Therapeutics LLC and that BCBSTX has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, prescription drug benefits to all persons entitled to prescription drug benefits under individual certificates, group health insurance policies and contracts to which BCBSTX is a party, including the Participants under the Contract. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. Pharmacy Benefit Managers may share a portion of those rebates with BCBSTX.

The Employer understands that BCBSTX may receive such rebates during the term of the Contract. Neither the Employer nor Participants hereunder are entitled to receive any portion of any such rebates in excess of any amount that may be reflected in the in the new group rates letter ("Letter") or the renewal exhibit ("Exhibit"); as part of any experience rating refund, if applicable to this Contract, or otherwise.

- AA. Service Mark Regulation:** On behalf of the Employer and its Participants, the Employer hereby expressly acknowledges its understanding that the Contract constitutes a contract solely between the Employer and BCBSTX. BCBSTX is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits BCBSTX to use the Blue Cross and Blue Shield Service Mark in BCBSTX's service area and BCBSTX is not contracting as the agent of the Association. The Employer further acknowledges and agrees that it has not entered into the Contract based upon representations by any person other than authorized persons of BCBSTX and that no person, entity or organization other than BCBSTX shall be held accountable or liable to the Employer for any of BCBSTX's obligations to the Employer created under the Contract. This paragraph shall not create any additional obligations whatsoever on the part of BCBSTX, other than those created under other provisions of this Group Administration Document.
- BB. Severability:** In case any one or more of the provisions contained in this Contract shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Contract and this Contract shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.
- CC. Third Party Data Release:** In the event the Employer directs BCBSTX to provide data directly to its third party consultant and/or vendor, the Employer acknowledges and agrees, and will cause its third party consultant and/or vendor to acknowledge and agree:
1. The personal and confidential nature of the requested documents, records and other information (for purposes of this section, "Confidential Information").
 2. Release of the Confidential Information may also reveal BCBSTX's confidential, business proprietary and trade secret information (for purposes of this section, "Proprietary Information").
 3. To maintain the confidentiality of the Confidential Information and any Proprietary Information (for purposes of this section, collectively, "Information").
 4. The third party consultant and/or vendor shall:
 - a. Use the Information only for the purpose of complying with the terms and conditions of its contract with the Employer.
 - b. Maintain the Information at a specific location under its control and take reasonable steps to safeguard the Information and to prevent unauthorized disclosure of the Information to third parties, including those of its employees not directly involved in the performance of duties under its contract with the Employer.
 - c. Advise its employees who receive the Information of the existence and terms of these provisions and of the obligations of confidentiality herein.
 - d. Use, and require its employees to use, at least the same degree of care to protect the Information as is used with its own proprietary and confidential information.
 - e. Not duplicate the Information furnished in written, pictorial, magnetic and/or other tangible form except for purposes of the Contract or as required by law.
 5. Not to use the name, logo, trademark or any description of each other or any subsidiary of each other in any advertising, promotion, solicitation or otherwise without the express prior written consent of the consenting party with respect to each proposed use.
 6. The third party consultant and/or vendor shall execute BCBSTX's then-current confidentiality agreement.
 7. The Employer shall designate the third party consultant and/or vendor on the appropriate HIPAA documentation.

8. The Employer shall provide BCBSTX with the appropriate authorization and specific written directions with respect to data release or exchange with the third party consultant and/or vendor.

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

DD. Time of Payment of Claims: Benefits available under this Contract for any loss will be paid not more than 60 days after receipt of written Proof of Loss.

EE. Verification of Eligibility: Upon written request by BCBSTX, the Employer shall provide such business records and other information in its possession to verify to BCBSTX a person's eligibility status. Such verification may be required prior to or after the Effective Date of coverage of a person, or after coverage has terminated. Such records and information may include, but are not limited to, birth and divorce documents retained by the Employer, reports to the Texas Workforce Commission, Workers' Compensation reports, or Federal FICA and withholding tax records.

FF. Premium Rebates and Premium Abatements:

Rebate: In the event federal or state law requires BCBSTX to rebate a portion of annual premiums paid, BCBSTX will provide any rebate owed as required or allowed by such federal or state law.

Abatement: BCBSTX may from time to time determine to abate (in whole or in part) the premium due under this Group Administration Document for particular period(s). In the case of each abatement, and in consideration of the same, the Employer is required to pay or credit a pro-rata share of the abated premium to its Employees covered under this Group Administration Document, in proportion to the amount that each Employee pays for the coverage under this Group Administration Document for the particular period(s).

In the alternative, if the Employer does not elect to pay or credit such abated premium to such Employees, the Employer is required, within 30 days after the notice to the Employer from BCBSTX of the abatement, (i) to notify BCBSTX that the Employer elects to forego the abatement, and (ii) to pay to BCBSTX the amounts previously abated and retained by the Employer. If the Employer elects to forego the abatement, such election will not affect the amount of any rebate owed the Employer under law.

Any abatement of premium by BCBSTX represents a determination by BCBSTX not to collect premium for the applicable period(s) and does not effect a reduction in the rates under the Group Administration Document. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

Administrative: The Employer shall provide BCBSTX with any information, records and documentation that BCBSTX may require or request with regard to the subject matter of this Section FF in a time, form and manner specified by BCBSTX. Further, the Employer shall develop and retain information, records and documentation evidencing the timely and accurate distribution or credit of any rebate and abatement and shall promptly provide such information, records and documentation to BCBSTX upon request. Such information, records and documentation shall include (but not be limited to):

1. The amount of the premium paid by each Employee or former Employee (if applicable);
2. The amount of the premium paid by the Employer;
3. The amount of the rebate or abatement provided to each Employee or former Employee (if applicable);

4. The amount of the rebate or abatement retained by the Employer;
5. The date(s) and method(s) in which the rebate or abatement was provided to each Employee or former Employee (if applicable); and
6. The amount of any unclaimed rebate or abatement and how and when it will be or was distributed.

BCBSTX will rely upon such information, records and documentation as accurate and complete.

BCBSTX makes no representation or warranty that any rebate or abatement owed or provided are exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of the Employer and each Employee or former Employee (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations. The Employer shall assure appropriate notification to federal and state tax agencies and that each payment to the Employees and former Employees will be accompanied by appropriate federal and state documentation, e.g., Form 1099 or W-2.

The Employer agrees to indemnify and hold BCBSTX harmless against any and all claims, demands, costs, fines, losses, interest, settlements, judgments, damages, penalties, taxes, expenses (including reasonable attorneys' fees) or other liabilities resulting from the Employer's failure to carry out its responsibilities or obligations as set forth in this Section FF of the Group Administration Document.

VII. BLUECARD

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

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

B. Liability Calculation Method Per Claim

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

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

1. The actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"), or
2. An estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"), or

3. An average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Participant and the Contractholder from the Actual Price than would an Estimated Price.

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

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

C. Return of Overpayments

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

VIII. NOTICE OF ANNUAL MEETING

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

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

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the Texas Insurance Code, Article 21.28-D.)

BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY OR MAY NOT COVER YOUR POLICY IN FULL.

Eligibility for Protection by the Association

When an insurance company, which is a member of the Association, is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- **Residents of Texas at the time that their insurance company is impaired**
- **Residents of other states, ONLY if the following conditions are met:**
 - 1) The policyholder has a policy with a company based in Texas;
 - 2) The company has never held a license in the policyholder's state of residence;
 - 3) The policyholder's state of residence has a similar guaranty association; and
 - 4) The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

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

Life Insurance:

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

Individual Annuities:

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

Group Annuities:

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

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

When you are selecting an insurance company, you should not rely on Association coverage.

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

www.txlifega.org

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

**AMENDMENT TO THE GROUP ADMINISTRATION DOCUMENT REGARDING CHANGES TO
YOUR GROUP HEALTH COVERAGE**

The DEFINITIONS section of your Group Administration Document is modified as follows:

Under: I. DEFINITIONS, the following definition is deleted:

Benefit Program Application means the initial application for the Contract. When fully executed, the Benefit Program Application shall become a part of the Contract.

Under: I. DEFINITIONS, the following definition is added:

Benefit Program Application means the initial application for the Contract. When fully executed, the Benefit Program Application shall become a part of the Contract. For the purposes of this Contract, the term "BPA" includes, if applicable, the initial Schedule of Specifications and/or Contract and/or applications signed by the Employer, and any subsequent Schedules of Specifications and/or Contract and/or applications and amendments thereto.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Contract to which this amendment is attached will remain in full force and effect. This amendment shall become effective on the Employer's Contract Anniversary Date or on the Plan Year of the Employer's Group Health Plan.

Blue Cross and Blue Shield of Texas
(BCBSTX)



By:
President, Blue Cross and Blue Shield of Texas

**The following “IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)” below is an update to page 21 of this Group
Administration Document**

**IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE
TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)**

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)
It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas (regardless of where the policyholder lived when the policy was issued)
- Residents of other states, ONLY if the following conditions are met:
 1. The policyholder has a policy with a company domiciled in Texas;
 2. The policyholder's state of residence has a similar guaranty association; and
 3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of \$500,000 for basic hospital, medical-surgical, and major medical insurance, \$300,000 for disability or long term care insurance, or \$200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of \$100,000 under one or more policies on a single life; or
- Death benefits up to a total of \$300,000 under one or more policies on a single life; or
- Total benefits up to a total of \$5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of \$250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of \$250,000 on any one life; or
- Present value of unallocated benefits up to a total of \$5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- \$300,000 on any one life with the exception of the \$500,000 health insurance limit, the \$5,000,000 multiple owner life insurance limit, and the \$5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.state.tx.us

Section II

Summary of Benefits

Your Health Care Benefits Program



Terrell County Ind School Dist
Group #22295 - High Plan

Managed Health Care
Pharmacy Benefits



BlueCross BlueShield of Texas

0222950001.0913

Schedule of Coverage



**BlueCross BlueShield
of Texas**

The following information summarizes the benefits available under the Managed Health Care Benefits section of your coverage. To get the most out of your coverage, it is important that you carefully read your Benefit Booklet so you are aware of plan requirements, provisions and limitations and exclusions.

High Plan

BlueChoice Network

Overall Payment Provisions		In-Network Benefits	Out-of-Network Benefits
Deductibles			
- Calendar Year Deductible - Three-month Deductible carryover applies - Combined In and Out-of-Network		\$100 Individual / \$300 Family	
Coinsurance Stop-Loss Amounts		\$1,000 Individual / \$3,000 Family	\$2,000 Individual / \$6,000 Family
Copayment Amounts Required			
Physician office visit/consultation		\$15 Copayment Amount	
Outpatient Hospital emergency room/treatment room visit		\$50 outpatient Hospital emergency room/treatment room visit Copayment Amount	\$50 outpatient Hospital emergency room/treatment room visit Copayment Amount
Maximum Lifetime Benefits			
Per Participant		Unlimited*	
Inpatient Hospital Expenses			
Inpatient Hospital Expenses			
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.		90% of Allowable Amount	70% of Allowable Amount
Penalty for failure to preauthorize services		None	\$250
Medical/Surgical Expenses			
Physician office visit/consultation, including lab and x-ray		100% of Allowable Amount after \$15 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Lab & x-ray in other outpatient facilities, excluding Certain Diagnostic Procedures		100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Inpatient visits and Certain Diagnostic Procedures		90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy		90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician surgical services performed in any setting		90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Schedule of Coverage



**BlueCross BlueShield
of Texas**

Extended Care Expenses	In-Network Benefits	Out-of-Network Benefits
Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount 25 days per Calendar Year* 60 visits per Calendar Year* Unlimited days lifetime maximum*	70% of Allowable Amount after Calendar Year Deductible
Special Provisions Expenses		
Behavioral Health Services		
Treatment of Chemical Dependency Preauthorization is required		
Inpatient Services Inpatient treatment must be provided in a Chemical Dependency Treatment Center	90% of Allowable Amount	70% of Allowable Amount
Behavioral Health Practitioner 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 \$15 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
Serious Mental Illness Preauthorization is required		
Inpatient Services Hospital services (facility)	90% of Allowable Amount	70% of Allowable Amount
Behavioral Health Practitioner 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 \$15 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

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
 A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Schedule of Coverage



**BlueCross BlueShield
of Texas**

Mental Health Care

Preauthorization is required

Inpatient Services Hospital services (facility)	90% of Allowable Amount	70% of Allowable Amount
Behavioral Health Practitioner 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 \$15 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

Emergency Room/Treatment Room

Accidental Injury & Emergency Care within first 48 hours (including Accidental Injury & Emergency Care for Behavioral Health Services) Facility charges	90% of Allowable Amount after \$50 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply)	
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 \$50 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply)	70% of Allowable Amount after \$50 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after 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 well baby care exams, routine lab and x-ray, annual vision exams, annual hearing exams and immunizations. Note: immunizations required by law for a Dependent child from birth through the date the child turns 6 years of age are covered at 100% of the Allowable Amount. Routine annual physical exam which includes but is not limited to diagnostic examination for early detection of cervical cancer (Pap smear) for female Participants age 18 and over	100% of Allowable Amount after \$15 Copayment Amount for Physician office visit 100% of Allowable Amount after \$15 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
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* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Schedule of Coverage



Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and older Outpatient facility or imaging centers	<i>100% of Allowable Amount after \$15 Copayment Amount</i> <i>100% of Allowable Amount</i>	<i>70% of Allowable Amount after Calendar Year Deductible</i> <i>70% of Allowable Amount after Calendar Year Deductible</i>
Bone mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for Qualified Individuals (refer to your booklet for details) Outpatient facility or imaging centers	<i>100% of Allowable Amount after \$15 Copayment Amount</i> <i>100% of Allowable Amount</i>	<i>70% of Allowable Amount after Calendar Year Deductible</i> <i>70% of Allowable Amount after Calendar Year Deductible</i>
Screening exams for the detection of colorectal cancer for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer: Physician services Outpatient facility Anesthesia charges	<i>100% of Allowable Amount after \$15 Copayment Amount</i> <i>90% of Allowable Amount after Calendar Year Deductible</i> <i>90% of Allowable Amount after Calendar Year Deductible</i>	<i>70% of Allowable Amount after Calendar Year Deductible</i> <i>70% of Allowable Amount after Calendar Year Deductible</i> <i>70% of Allowable Amount after Calendar Year Deductible</i>
Routine annual physical exam For male Participants who are at least 50 years of age and asymptomatic or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor: Diagnostic examination for the detection of prostate cancer and Prostate-specific antigen test used for the detection of prostate cancer	<i>100% of Allowable Amount after \$15 Copayment Amount</i> <i>100% of Allowable Amount after \$15 Copayment Amount</i> <i>100% of Allowable Amount after \$15 Copayment Amount</i>	<i>70% of Allowable Amount after Calendar Year Deductible</i> <i>70% of Allowable Amount after Calendar Year Deductible</i> <i>70% of Allowable Amount after Calendar Year Deductible</i>
One of the following early detection tests for cardiovascular disease will be covered for a Participant who meets the age requirements and is a diabetic or has been determined to have a risk of developing coronary heart disease: - Computed tomography (CT) scanning measuring artery calcification. - Ultrasonography measuring carotid intim-media thickness and plaque.	<i>90% of Allowable Amount after Calendar Year Deductible</i> <i>Maximum benefit of \$200 for one test every 5 years*</i>	<i>70% of Allowable Amount after Calendar Year Deductible</i>

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Schedule of Coverage



**BlueCross BlueShield
of Texas**

Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing function with hearing aids

Covered as any other sickness

Covered as any other sickness

Hearing Aids

*90% of Allowable Amount after
Calendar Year Deductible*

*70% of Allowable Amount after
Calendar Year Deductible*

Hearing Aids maximum

*Hearing Aids are subject to a \$1,000 maximum amount each 36-Month period**

Physical Medicine Services

Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)

*90% of Allowable Amount after
Calendar Year Deductible*

*70% of Allowable Amount after
Calendar Year Deductible*

Calendar Year maximum

*35 visits each Calendar Year**

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Schedule of Coverage



BlueCross BlueShield
of Texas

The following chart summarizes the pharmacy benefits available under your coverage. To get the most out of your coverage, it is important that you carefully read the **PHARMACY BENEFITS** section of your Benefit Booklet so you are aware of plan requirements, provisions, limitations and exclusions.

Pharmacy Benefits	Participating Pharmacy	Non-Participating Pharmacy (member files claims)
Retail Pharmacy		
One Copayment Amount per 30-day supply, up to a 90-day supply	\$3 Copayment Amount – Generic Drugs \$5 Copayment Amount* – Preferred Brand Name Drug \$20 Copayment Amount* – Non-Preferred Brand Name Drug	80% of Allowable Amount minus Copayment Amount*
Mail-Order Program		
One Copayment Amount per 30-day supply, up to a 90-day supply	\$3 Copayment Amount – Generic Drugs \$5 Copayment Amount* – Preferred Brand Name Drug \$20 Copayment Amount* – Non-Preferred Brand Name Drug	XXXXXXXXXXXXXXXXXXXXXXX
Specialty Drugs	Specialty Pharmacy Provider	Other Pharmacy
Available In-Network through Specialty Pharmacy Program		
One Copayment Amount per 30-day supply - limited to a 30-day supply	\$3 Copayment Amount – Generic Specialty Drugs \$5 Copayment Amount* – Preferred Brand Name Specialty Drug \$20 Copayment Amount* – Non-Preferred Brand Name Specialty Drug	80% of Allowable Amount minus Copayment Amount*
Vaccinations obtained through Pharmacies**	Participating Pharmacy	Non-Participating Pharmacy (member files claims)
	Flu vaccine - \$0 Copayment Amount	80% of Allowable Amount less any applicable Copayment Amount
Diabetes Supplies are available under the Pharmacy Benefits portion of your Plan. All provisions of this portion of the Plan will apply including any Deductibles, Copayment Amounts, and any pricing differences.		

* If you receive a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Pharmacy Benefits portion of your booklet for details.

** Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Preferred Drug List 1 applies.

Pharmacy Network A applies.

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

Terrell County ISD: Custom Plan (Grandfathered)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual+Family | Plan Type: PPO Coverage Period: 09/01/2013 – 08/31/2014



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com or by calling 1-800-521-2227.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In- and Out-of-Network \$100 Individual/\$300 Family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For In-Network \$1,000 Individual/\$3,000 Family For Out-of-Network \$2,000 Individual/\$6,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Deductibles, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.bcbstx.com or call 1-800-810-2583 (BLUE) for a list of In-Network providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term <u>in-network</u> , preferred, or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary

At <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.

Terrell County ISD: Custom Plan (Grandfathered)

Coverage Period: 09/01/2013 – 08/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual+Family | Plan Type: PPO



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use In-Network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	30% coinsurance	---none---
	Specialist visit	\$15 copay/visit	30% coinsurance	---none---
	Other practitioner office visit	\$15 copay/visit	30% coinsurance	Applies to Chiropractic care services. Limited to 35 visits per calendar year.
	Preventive care/screening/immunization	\$15 copay/visit	30% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	Deductible waived In-Network.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	---none---
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbstx.com .	Generic drugs	\$3 copay/prescription (retail and mail)	20% coinsurance after \$3 copay/prescription (retail)	Retail and Mail order copays are based on a 30 day supply. With appropriate prescription order, up to 90 day supply is available. Mail order is not available Out-of-Network.
	Preferred brand drugs	\$5 copay/prescription (retail and mail)	20% coinsurance after \$5 copay/prescription (retail)	
	Non-preferred brand drugs	\$20 copay/prescription (retail and mail)	20% coinsurance after \$20 copay/prescription (retail)	

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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Terrell County ISD: Custom Plan (Grandfathered)

Coverage Period: 09/01/2013 – 08/31/2014
Coverage for: Individual+Family | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Specialty drugs	Covered same as any other drug	Covered same as any other drug	Mail order is not available.
	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	---none---
	Physician/surgeon fees	10% coinsurance	30% coinsurance	---none---
If you need immediate medical attention	Emergency room services	10% coinsurance after \$50 copay/visit	10% coinsurance after \$50 copay/visit	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	---none---
	Urgent care	\$15 copay/visit	30% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Deductible waived In-Network. Preauthorization required. \$250 penalty applies for failure to preauthorize Out-of-Network.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	---none---
	Mental/Behavioral health outpatient services	\$15 copay/visit	30% coinsurance	Certain services must be preauthorized, refer to benefit booklet for details.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	All services must be preauthorized. \$250 penalty for failure to preauthorize Out-of-network.
	Substance use disorder outpatient services	\$15 copay/visit	30% coinsurance	Certain services must be preauthorized, refer to benefit booklet for details.
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	All services must be preauthorized. \$250 penalty for failure to preauthorize Out-of-network.
If you are pregnant	Prenatal and postnatal care	\$15 copay/initial visit	30% coinsurance	10% coinsurance applies after initial visit.

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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Terrell County ISD: Custom Plan (Grandfathered)

Coverage Period: 09/01/2013 – 08/31/2014
Coverage for: Individual+Family | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Preauthorization required. \$250 penalty for failure to preauthorize.
	Home health care	10% coinsurance	30% coinsurance	Preauthorization required. Limited to 60 visits per calendar year. Deductible waived In-Network.
	Rehabilitation services	10% coinsurance	30% coinsurance	Includes but not limited to physical, occupational, and manipulative therapy. Limited to 35 visits per calendar year.
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Preauthorization required. Limited to 25 days per calendar year. Deductible waived In-Network.
	Durable medical equipment	10% coinsurance	30% coinsurance	---none---
If your child needs dental or eye care	Hospice service	10% coinsurance	30% coinsurance	Preauthorization required. Deductible waived In-Network.
	Eye exam	\$15 copay/visit	30% coinsurance	---none---
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)			
- Acupuncture - Bariatric surgery - Cosmetic surgery	- Dental care (Adult, except if related to accident) - Infertility treatment - Long-term care	- Private-duty nursing - Routine foot care (covered only for specific diagnoses) - Weight loss programs	

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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Terrell County ISD: Custom Plan (Grandfathered)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care	• Non-emergency care when traveling	• Routine eye care (Adult)
• Hearing aids (\$1,000 max per each 36-month period)	outside the U.S.	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cco.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: www.texashealthoptions.com.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-521-2227.

Navajo (Dine): Dineek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-800-521-2227.

—————To see examples of how this plan might cover costs for a sample medical situation, see the next page.—————

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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Terrell County ISD: Custom Plan (Grandfathered)

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 09/01/2013 – 08/31/2014

Coverage for: Individual+Family | Plan Type: PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,590
- Patient pays \$950

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540
Patient pays:	
Deductibles	\$100
Copays	\$0
Coinsurance	\$40
Limits or exclusions	\$660
Total	\$950

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,770
- Patient pays \$630

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400
Patient pays:	
Deductibles	\$100
Copays	\$330
Coinsurance	\$120
Limits or exclusions	\$80
Total	\$630

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary

At <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Your Health Care Benefits Program



Terrell County Ind School Dist
Group #22295 - Low Plan

Managed Health Care
Pharmacy Benefits



BlueCross BlueShield of Texas

0222950004.0913

Schedule of Coverage



The following information summarizes the benefits available under the Managed Health Care Benefits section of your coverage. To get the most out of your coverage, it is important that you carefully read your Benefit Booklet so you are aware of plan requirements, provisions and limitations and exclusions.

Low Plan

BlueChoice Network

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
- Calendar Year Deductible - Three-month Deductible carryover applies - Combined In and Out-of-Network - Applies to all Eligible Expenses	\$1,000 Individual / \$3,000 Family	
Coinurance Stop-Loss Amounts	\$3,000 Individual / \$9,000 Family	\$6,000 Individual / \$18,000 Family
Copayment Amounts Required		
Physician office visit/consultation	\$25 Copayment Amount	
Urgent Care center visit	\$50 Copayment Amount	
Outpatient Hospital emergency room/treatment room visit	\$100 outpatient Hospital emergency room/treatment room visit Copayment Amount	\$100 outpatient Hospital emergency room/treatment room visit Copayment Amount
Maximum Lifetime Benefits		
Per Participant	Unlimited	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Penalty for failure to preauthorize services	None	\$250
Medical/Surgical Expenses		
Physician office visit/consultation, including lab and x-ray	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Lab & x-ray in other outpatient facilities, excluding Certain Diagnostic Procedures	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Inpatient visits and Certain Diagnostic Procedures	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Physician surgical services performed in any setting	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
 A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Schedule of Coverage



**BlueCross BlueShield
of Texas**

<i>Extended Care Expenses</i>	<i>In-Network Benefits</i>	<i>Out-of-Network Benefits</i>
	<i>100% of Allowable Amount</i>	<i>70% of Allowable Amount after Calendar Year Deductible</i>
Skilled Nursing Facility	<i>25 days per Calendar Year</i>	
Home Health Care	<i>60 visits per Calendar Year*</i>	
Hospice Care	<i>Unlimited days lifetime maximum*</i>	
Special Provisions Expenses		
Behavioral Health Services		
Treatment of Chemical Dependency		
Preauthorization is required		
Inpatient Services Inpatient treatment must be provided in a Chemical De- pendency Treatment Center	<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>60% of Allowable Amount after Calendar Year Deductible</i>
Behavioral Health Practitioner services	<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>60% of Allowable Amount after Calendar Year Deductible</i>
Outpatient Services Behavioral Health Practitioner expenses (office setting)	<i>100% of Allowable Amount after \$25 Copayment Amount</i>	<i>70% of Allowable Amount after Calendar Year Deductible</i>
Other outpatient services	<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>60% of Allowable Amount after Calendar Year Deductible</i>
Serious Mental Illness		
Preauthorization is required		
Inpatient Services Hospital services (facility)	<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>60% of Allowable Amount after Calendar Year Deductible</i>
Behavioral Health Practitioner services	<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>60% of Allowable Amount after Calendar Year Deductible</i>
Outpatient Services Behavioral Health Practitioner expenses (office setting)	<i>100% of Allowable Amount after \$25 Copayment Amount</i>	<i>70% of Allowable Amount after Calendar Year Deductible</i>
Other outpatient services	<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>60% of Allowable Amount after Calendar Year Deductible</i>
Mental Health Care		
Preauthorization is required		
Inpatient Services Hospital services (facility)	<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>60% of Allowable Amount after Calendar Year Deductible</i>
Behavioral Health Practitioner services	<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>60% of Allowable Amount after Calendar Year Deductible</i>

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
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Schedule of Coverage



**BlueCross BlueShield
of Texas**

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	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care within first 48 hours (including Accidental Injury & Emergency Care for Behavioral Health Services)		
Facility charges	80% of Allowable Amount after \$100 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply)	
Physician charges	80% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)		
Facility charges	80% of Allowable Amount after \$100 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply)	60% of Allowable Amount after \$100 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible
Physician charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (excluding Certain Diagnostic Procedures)	100% of Allowable Amount after \$50 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Services received during an Urgent Care visit - Certain Diagnostic Procedures	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services		
80% of Allowable Amount after Calendar Year Deductible		
Preventive Care		
Routine well baby care exams, routine lab and x-ray, annual vision exams, annual hearing exams and immunizations.	100% of Allowable Amount after \$25 Copayment Amount for Physician office visit	70% of Allowable Amount after Calendar Year Deductible
Note: immunizations required by law for a Dependent child from birth through the date the child turns 6 years of age are covered at 100% of the Allowable Amount.		
Routine annual physical exam which includes but is not limited to diagnostic examination for early detection of cervical cancer (Pap smear) for female Participants age 18 and over	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Annual screening by low-dose mammography for the presence of occult breast cancer for female participants age 35 and older	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
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Schedule of Coverage



**BlueCross BlueShield
of Texas**

Outpatient facility or imaging centers	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Bone mass measurement for the detection of low bone mass to determine risk of osteoporosis and fractures associated with osteoporosis for Qualified Individuals (refer to your booklet for details)	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Outpatient facility or imaging centers	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Screening exams for the detection of colorectal cancer for Participants who are 50 years of age or older and who are at normal risk for developing colon cancer:		
Physician services	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Outpatient facility	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Anesthesia charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Routine annual physical exam	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
For male Participants who are at least 50 years of age and asymptomatic or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor:		
Diagnostic examination for the detection of prostate cancer and	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Prostate-specific antigen test used for the detection of prostate cancer	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
One of the following early detection tests for cardiovascular disease will be covered for a Participant who meets the age requirements and is a diabetic or has been determined to have a risk of developing coronary heart disease:	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
- Computed tomography (CT) scanning measuring artery calcification. - Ultrasonography measuring carotoid intim-media thickness and plaque.	Maximum benefit of \$200 for one test every 5 years*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
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Schedule of Coverage



**BlueCross BlueShield
of Texas**

Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing function with hearing aids

Covered as any other sickness

Covered as any other sickness

Hearing Aids

*80% of Allowable Amount after
Calendar Year Deductible*

*60% of Allowable Amount after
Calendar Year Deductible*

Hearing Aids maximum

*Hearing Aids are subject to a \$1,000 maximum amount each 36-Month period**

Physical Medicine Services

Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)

*80% of Allowable Amount after
Calendar Year Deductible*

*60% of Allowable Amount after
Calendar Year Deductible*

Calendar Year maximum

*35 visits each Calendar Year**

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Schedule of Coverage



BlueCross BlueShield
of Texas

The following chart summarizes the pharmacy benefits available under your coverage. To get the most out of your coverage, it is important that you carefully read the **PHARMACY BENEFITS** section of your Benefit Booklet so you are aware of plan requirements, provisions, limitations and exclusions.

Pharmacy Benefits	Participating Pharmacy	Non-Participating Pharmacy (member files claims)
Retail Pharmacy		
One Copayment Amount per 30-day supply, up to a 90-day supply	\$20 Copayment Amount – Generic Drugs \$35 Copayment Amount* – Preferred Brand Name Drug \$50 Copayment Amount* – Non-Preferred Brand Name Drug	80% of Allowable Amount minus Copayment Amount*
Mail-Order Program		
One Copayment Amount per 30-day supply, up to a 90-day supply	\$20 Copayment Amount – Generic Drugs \$35 Copayment Amount* – Preferred Brand Name Drug \$50 Copayment Amount* – Non-Preferred Brand Name Drug	XXXXXXXXXXXXXXXXXXXXXXX
Diabetes Supplies are available under the Pharmacy Benefits portion of your Plan. All provisions of this portion of the Plan will apply including any Deductibles, Copayment Amounts, and any pricing differences.		

* If you receive a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Pharmacy Benefits portion of your booklet for details.

Preferred Drug List 1 applies.

Pharmacy Network A applies.

Terrell County ISD: RM09

Coverage Period: 10/01/2013 – 09/30/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual/Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com or by calling 1-800-521-2227.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-Network and Out-of-Network \$1,000 Individual/ \$3,000 Family. Preventive care, copays, and generic drugs do not apply to the In-Network deductible.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For In-Network \$3,000 Individual/ \$9,000 Family For Out-of-Network \$6,000 Individual/ \$18,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Deductibles, premiums, balance-billed charges, pharmacy/drugs and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> , or the <u>stop-loss limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.bcbstx.com or call 1-800-810-BLUE for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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

Terrell County ISD: RM09

Coverage Period: 09/01/2013 – 08/31/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	30% coinsurance	---none---
	Specialist visit	\$25 copay/visit	30% coinsurance	
	Other practitioner office visit	\$25 copay/visit	30% coinsurance	
If you have a test	Preventive care/screening/immunization	No Charge	30% coinsurance	There is no charge for Out-of-Network immunizations from birth through the day of the 6 th birthday.
	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	Deductible waived In-Network.
If you need drugs to treat your illness or condition	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	---none---
	Generic drugs	\$20 copay/prescription	20% coinsurance plus copay	Copay amounts are per 30-day supply for retail and mail orders. Preferred Drug List 1 applies.
	Preferred brand drugs	\$35 copay/prescription	20% coinsurance plus copay	
	Non-preferred brand drugs	\$50 copay/prescription	20% coinsurance plus copay	
	Specialty drugs	\$20/\$35/\$50 copay/prescription	20% coinsurance plus copay	
	More information about <u>prescription drug coverage</u> is available at www.bcbstx.com/member/rx_drugs.html			

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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Terrell County ISD: RM09

Coverage Period: 09/01/2013 – 08/31/2014
Coverage for: Individual/Family | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance after \$100 copay/visit	20% coinsurance after \$100 copay/visit	Copay amount waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	\$50 copay/visit	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required and there is a \$250 penalty if out-of-network is not preauthorized.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	40% coinsurance	Certain service must be preauthorized; refer to benefit booklet for details. \$25 copay per office visit in lieu of coinsurance for In-Network and 30% coinsurance for Out-of-Network office visit.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	20% coinsurance	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	\$25 copay/initial visit only	30% coinsurance	---none---
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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Terrell County ISD: RM09

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage Period: 09/01/2013 – 08/31/2014
Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	All services must be preauthorized. Limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	20% coinsurance	40% coinsurance	Limited to 35 visits per calendar year.
	Skilled nursing care	No Charge	30% coinsurance	All services must be preauthorized. Limited to 25 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
If your child needs dental or eye care	Hospice service	No Charge	30% coinsurance	All services must be preauthorized.
	Eye exam	\$25 copay/visit	30% coinsurance	
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)			
• Acupuncture	• Dental care (Adult)	• Private-duty nursing	
• Bariatric surgery	• Long-term care	• Routine foot care (only covered for the diagnosis of Diabetes)	
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss programs	

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Infertility treatment (In vitro and Artificial Insemination are not covered unless shown in your plan document)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact BlueCross BlueShield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact: Texas Department of Insurance's Consumer Health Assistance Program at (855) 839-2427 or visit www.texashealthoptions.com.

Language Access Services:

- Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
- Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
- Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-521-2227.
- Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,220
- Patient pays \$2,320

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,000
Copays	\$20
Coinurance	\$1,150
Limits or exclusions	\$150
Total	\$2,320

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,240
- Patient pays \$2,160

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,000
Copays	\$870
Coinurance	\$210
Limits or exclusions	\$80
Total	\$2,160

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf> or call 1-855-756-4448 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

x No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

x No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Section III

Premium Rate Sheet

Buy Up Plan

Tier	Premium	District Contribution	Employee Contribution
Employee Only	\$ 671.63	\$531.95	\$ 139.68
Employee & Child(ren)	\$1,184.05	\$531.95	\$ 652.10
Employee & Spouse	\$1,596.84	\$531.95	\$1,064.89
Employee & Family	\$1,970.91	\$531.95	\$1,438.96

Low Plan

Tier	Premium	District Contribution	Employee Contribution
Employee Only	\$ 531.95	\$531.95	\$ 0.00
Employee & Child(ren)	\$ 950.43	\$531.95	\$418.48
Employee & Spouse	\$1,281.78	\$531.95	\$749.83
Employee & Family	\$1,582.06	\$531.95	\$1,050.11

Section IV

Enrollment Data



ENROLLMENT BY TYPE OF COVERAGE

Report Description: This report provides a high-level view of TERRELL COUNTY IND SCHOOL DIST: ALL's membership, broken down by employee status. These numbers show if a certain employee status was a key driver to any changes in overall membership for the current reporting month and for the year to date.

TERRELL COUNTY IND SCHOOL DIST: ALL			
AVERAGE ENROLLED MEMBERSHIP BY EMPLOYEE STATUS FOR JAN'14			
EMPLOYEE STATUS	MEDICAL	PHARMACY	DENTAL
ACTIVE	56	56	
RETIREE UNDER 65			
RETIREE 65 AND OVER			
COBRA			
SUMMARY	56	56	

TERRELL COUNTY IND SCHOOL DIST: ALL			
AVERAGE ENROLLED MEMBERSHIP BY EMPLOYEE STATUS FOR YEAR TO DATE			
EMPLOYEE STATUS	MEDICAL	PHARMACY	DENTAL
ACTIVE	56	56	
RETIREE UNDER 65			
RETIREE 65 AND OVER			
COBRA			
SUMMARY	56	56	

Section V

Comparability Report Form

TEACHER RETIREMENT SYSTEM OF TEXAS
1000 Red River Street, Austin, Texas 78701-2698
Telephone (512) 542-6446 or (800) 223-8778 Ext. 6446
www.trs.state.tx.us

2013-2014 Comparability Report Form

Please complete and mail no later than April 1, 2014 to:

Ms. Rosa Franco
TRS-ActiveCare - 2013-2014 Comparability Report
Teacher Retirement System of Texas
1000 Red River Street
Austin, TX 78701-2698

TRS District Number: 1667

District Name: Terrell County Independent School District

Does your district offer employee health coverage that
is comparable to HealthSelect?

Yes X No

Is your district in compliance with all other requirements
of Section 22.004 of the Education Code?

Yes X No

I certify that, based on my personal knowledge, the information provided above is true and accurate.


Signature of School Official

April 1, 2014
Date

Gary D. Hamilton
Name of School Official (Print or Type)

Superintendent
Title (Print or Type)

(432) 345-2515 ext.101
Phone number

Note: This form is the only documentation that should be submitted by your district to TRS. Do not provide any additional documentation such as the district's contract for group health coverage, schedule of benefits, premium rate sheet, etc.

For questions concerning the 2013-2014 Comparability Report Form, please contact Rosa Franco at (512) 542-6396.

Section VI

Compliance Statement

Date: February 24, 2014

From: Blain Chriesman, Business Manager

**Compliance Statement
Regarding Comparability of Healthcare**

Terrell County Independent School District (TCISD) offers health insurance coverage to eligible employees. TCISD has a partially self-funded plan instead of TRS-ActiveCare Plan. TCISD covers approximately 56 employees with the health care coverage plan options currently in place.

We are required to send a report to the Teacher Retirement System of Texas every two years to confirm that TCISD medical coverage is comparable to the HealthSelect Plan. This report is called the Comparability Report Form.

TCISD completed a comparison of the two plans using the available information from HealthSelect as of September 1, 2013. The TCISD In-Network plan for employees is comparable to HealthSelect in side-by-side comparisons and is in compliance with other requirements of Section 22.004 of the Education Code.

Terrell County Independent School District
2013 TRS COMPARISON OPTIONS

BENEFITS	TGISD HIGH MEDICAL PLAN		TCISD LOW MEDICAL PLAN		HealthSelect		TRS ACTIVE CARE 2	
DEDUCTIBLE CAL/YR	\$100 IN / OON Combined		\$1,000 IN / OON Combined		\$0 IN / \$500 OON		\$1,000 IN / \$2,000 OON	
COSHARE STOP LOSS	\$1,000 IN / \$2,000 OON		\$3,000 IN / \$6,000 OON		\$2,000 IN / \$7,000 OON		\$4,000 IN / \$8,000 OON	
LIFETIME MAXIMUM	Unlimited		Unlimited		Unlimited		Unlimited	
PRIMARY CARE PHYSICIAN REQUIRED?	No		No		Yes IN / No OON		No	
IN-PATIENT HOSPITAL	90% IN / 70% OON After CYD	***	80% IN / 60% OON after CYD	***	80% IN / 60% OON After Copay	***	80% IN / 60% OON after CYD	
DEDUCTIBLE PER ADM.	None		None		\$150/day + Coin (\$750 max/admit)		\$150/day + Coins (\$750 max/admit)	
OUTPATIENT SURGERY	90% IN / 70% OON After CYD		80% IN / 60% OON after CYD		80% IN / 60% OON After Copay		80% IN / 60% OON after CYD	
DEDUCTIBLE PER ADM.	None		None		\$100 Copay + Coins		\$150 Copay/visit + Coins	
HIGH TECH RADIOLOGY	90% IN / 70% OON After CYD		80% IN / 60% OON after CYD	**	80% IN / 60% OON After Copay		80% IN / 60% OON after CYD	
COPAY			None		\$100 Copay		\$100 Copay	
MEDICAL/SURGICAL								
OFFICE VISIT - PRIMARY	\$15 / 100%		\$25 / 100%		\$25 Copay / 100%		\$30 Copay/ 100%	
OFFICE VISIT - SPECIALIST	\$15 / 100%		\$25 / 100%		\$40 Copay / 100%		\$50 Copay/ 100%	
IN-PATIENT VISIT	90% IN / 70% OON After CYD	***	80% IN / 60% OON after CYD	***	80% IN / 60% OON After Copay	***	80% IN / 60% OON after CYD	
SURGERY	90% IN / 70% OON After CYD		80% IN / 60% OON after CYD		80% IN / 60% OON After Copay		80% IN / 60% OON after CYD	
CHEMICAL DEPENDENCY	90% IN / 70% OON After CYD	***	80% IN / 60% OON after CYD	***	\$150/day + Coin (\$750 max/admit)	***	\$150/day + Coins (\$750 max/admit)	
SERIOUS MENTAL ILLNESS	90% IN / 70% OON After CYD		80% IN / 60% OON after CYD		\$150/day + Coin (\$750 max/admit)		\$150/day + Coins (\$750 max/admit)	
MENTAL HEALTH CARE	90% after CYD		80% after CYD		\$150/day + Coin (\$750 max/admit)	***	\$150/day + Coins (\$750 max/admit)	
EMERGENCY ROOM COPAY	90% after CYD	***	80% after CYD	***	\$150 Copay		\$150 Copay	
EMERGENCY CARE	\$50 Copay		\$100 Copay					
ACCIDENT & MEDICAL	90% after CYD		80% after CYD		80% After CYD		80% after CYD	
HOSPITAL	90% after \$50 Copay		80% after \$100 Copay		\$150/day + Coin (\$750 max/admit)		\$150/day + Coins (\$750 max/admit)	
PHYSICIAN	90% after CYD		80% after CYD		80% After CYD		80% after CYD	
AMBULANCE	90% after CYD		80% after CYD		80% After CYD		80% after CYD	
PREVENTIVE CARE	100%	*	100%	*	100%	*	100%	
CHIROPRACTIC SERVICES	35 Visits Per Yr		35 Visits Per Yr		30 Visits Per Yr		35 Visits Per Yr	
OFFICE VISIT	100% after \$15 Copay		100% after \$25 Copay		100% After \$40 Copay		100% after \$50 Copay	
OTHER OUTPATIENT SERVICES	90% after CYD		80% after CYD		80% After CYD		80% after CYD	
PHYSICAL MEDICINE								
OFFICE VISITS	100% after \$15 Copay		100% after \$25 Copay		80% After \$40 Copay		100% after \$50 Copay	
ALL OTHER SERVICES	90% after CYD		80% after CYD		80% After CYD		80% after CYD	
PRESCRIPTION DRUG								
DEDUCTIBLE	None		None		None		\$200 per person (low Brand only)	
GENERIC	\$3		\$20	****	\$15 / \$20		\$20 / \$25 / \$45	
BRAND PREFERRED	\$5		\$35	****	\$35 / \$45		\$40 / \$50 / \$105	
BRAND NON PREFERRED	\$20		\$50	****	\$60 / \$75		\$65 / \$80 / \$180	
SPECIALTY DRUGS	N/A		N/A		N/A		\$200 per fill	
30 Day Supply	1 Copay		1 Copay		1 Copay		see above	
60 Day Supply	1 Copay		1 Copay		2 Copays		see above	
90 Day Supply	1 Copay		1 Copay		3 Copays		see above	
MAIL ORDER REQUIRED	No		No		No		No	
RATES								
Employee Only	9/1/2013		9/1/2013		9/1/2013		9/1/2013	
Employee & Child(ren)	\$671.63		\$531.95		\$503.14		\$529.00	
Employee & Spouse	\$1,184.05		\$950.43		\$888.86		\$841.00	
Employee & Family	\$1,586.84		\$1,281.78		\$1,079.18		\$1,203.00	
	\$1,970.91		\$1,582.06		\$1,464.90		\$1,323.00	

* Under the Affordable Care Act, certain preventive health services are paid at 100% conditioned upon physician billing and diagnosis. In some cases, you will still be responsible for payment on some services.

** No copay if high-tech radiology performed during ER Visit or inpatient admission.

*** Prescription required

**** \$15/\$35/\$60 Copayments for non-maintenance drugs and \$20/\$45/\$75 Copayments for Maintenance Drugs