Your Health Care Benefits Program

Willis ISD

Group #036595

In-Hospital Indemnity Benefits

Administered by:

BlueCross BlueShield of Texas

September 1, 2023

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WILLIS ISD

SCHEDULE OF COVERAGE

Benefits described in this booklet apply only if also listed here.

COVERAGE CODE – SC9
DEPT. NO. – 0000
GROUP NO. - 36595

IN-HOSPITAL INDEMNITY BENEFITS

DAILY ALLOWANCE	$140.00	
NUMBER OF BENEFIT DAYS		
REGULAR BED-PATIENT ADMISSIONS		365
SPECIAL BED-PATIENT ADMISSIONS		
MENTAL HEALTH CARE	365	
CHEMICAL DEPENDENCY		365

INTRODUCTION

EXPLANATION

This Plan has been designed and selected by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses. Please read this Benefit Booklet carefully so you will be aware of the benefits and requirements of the Plan.

The daily Hospital room allowances which apply to your coverage are shown on the Schedule of Coverage.

CUSTOMER SERVICE HELPLINE

The Customer Service Helpline can:

- Distribute claim forms
- Answer your questions on claims
- Provide information on the features of the Plan

You can reach the Customer Service Helpline Monday through Friday from 8:00 a.m. to 8:00 p.m., Central Time.

Dallas area: (972) 669-3900
0Toll free: 1-800-521-2227

WHO GETS BENEFITS

ELIGIBILITY REQUIREMENTS FOR COVERAGE

Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes an Employee and is in a class eligible to be covered under the Plan. The Eligibility Date is the date the Employee completes the waiting period (the number of days of continuous employment required by the Employer) for coverage.

Employee Eligibility
You are eligible for coverage under the Plan if you are a full-time Employee as described in **Definitions** in this Benefit Booklet. You may apply for coverage on or before your Eligibility Date. If you are a retired Employee and your Employer provides coverage for retired Employees, you may continue your coverage under the Plan, but only if you were covered under the Employer's health care plan as an Employee on the date of retirement.

EFFECTIVE DATES

The effective date is the date coverage for an Employee actually begins. It may be different from the Eligibility Date.

Actively at Work/Non-Confinement Requirements
Coverage under the Plan will become effective as explained below, but only if you have satisfied the Actively at Work/Non-Confinement requirements on the date coverage is to become effective. Refer to **Definitions** in this Benefit Booklet for an explanation of Actively at Work/Non-Confinement.

If you have not satisfied the Actively at Work/Non-Confinement requirements on the date coverage would otherwise become effective, the coverage will become effective on the date following the first day you satisfy the requirements.

Timely Applications
It is important that your application for coverage under the Plan is received timely by the Plan Administrator. If you apply for coverage and if you:

1. Are eligible on the Plan Effective Date and the application is received by the Claims Administrator within 10 days of the Plan Effective Date, the coverage will become effective on the Plan Effective Date; or

2. Become eligible on or after the Plan Effective Date and the application is received by the Claims Administrator through the Plan Administrator within the first 30 days following your Eligibility Date, the coverage will become effective as provided in the Plan (see your Employer for this effective date information).

Late Applications
If you apply for coverage and the application is received by the Claims Administrator more than 30 days following your Eligibility Date, coverage may not be available to you. You will be required to submit to the Plan Administrator evidence of insurability at your own expense. If the Claims Administrator provides a written notice of acceptance, your coverage will become effective on the first day of the Plan Month following the date the Claims Administrator provides the written notice of acceptance.

HOW TO RECEIVE BENEFITS

BENEFITS PROVIDED

If you receive Care as a bed patient in a Hospital or a Facility, benefits will be provided as described below:

Daily Allowance

The daily allowance specified on the Schedule of Coverage will be available for each day of a Bed-Patient Admission.

Number of Benefit Days

The maximum number of benefit days to which the daily allowance described above is applicable during any one Period of Bed-Patient Confinement is specified on the Schedule of Coverage, subject to the following provisions:

1. For all *regular* Bed-Patient Admissions during any one Period of Bed-Patient Confinement, the maximum number of benefit days available for that Period of Bed-Patient Confinement will be the number specified on the Schedule of Coverage.

2. For all *special* Bed-Patient Admissions during any one Period of Bed-Patient Confinement, the maximum number of benefit days available for that Period of Bed-Patient Confinement will be the number specified for either "Mental Health Care" and/or "Chemical Dependency" as specified on the Schedule of Coverage.

3. For any combination of *regular* and *special* Bed-Patient Admissions during any one Period of Bed-Patient Confinement, the maximum number of benefit days available will not exceed the number specified on your Schedule of Coverage.

4. The benefits provided by the Plan for treatment of Chemical Dependency are available only for Care in a Substance Abuse Facility, except for the portion of a Bed-Patient Admission in a Hospital that is for medical management of acute life-threatening intoxication (toxicity).

For purposes of this benefit Section, the term

- *regular* Bed-Patient Admissions will apply to all Bed-Patient Admissions except for admissions for Mental Health Care or for treatment of Chemical Dependency. Admissions for treatment of Serious Mental Illness will be considered *regular* Bed-Patient Admissions.
- *special* Bed-Patient Admissions may apply to admissions for either Mental Health Care; or treatment of Chemical Dependency, or both, as specified on the Schedule of Coverage.

CLAIM FILING PROCEDURES

Filing of Claims Required

Notice of Claim

A claim prepared and submitted to the Plan through the Claims Administrator in the proper manner and form and in the time requested, must be received by the Claims Administrator before it can consider any claim for payment of benefits for Care provided to you.

Claim Forms

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

Who Files Claims

You must submit your own claims to the Claims Administrator using a form provided by the Plan. Your Employer should have a supply of claim forms.

Include itemized bills from the Hospital showing the services performed, dates of service, charges and name of the Participant involved.

Where to Mail Completed Claim Forms

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

Who Receives Payment

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

Nonassignment and Payment of Benefits

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

When to Submit Claims

All claims for benefits under the Plan must be properly submitted within 12 months of the date you receive the Care. Claims not submitted and received by the Claims Administrator within 12 months after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by the Plan

A claim will be considered received by the Plan for processing upon actual delivery to the Claims Administrator in the proper manner and form and with all of the information required. If the claim is not complete, it will be returned by the Claims Administrator. On claims for which further information is needed for proper processing, the Claims Administrator will contact either you or the Provider for the additional information. The claims cannot be processed until the Claims Administrator receives the requested information.

Review of Claim Determinations

Claims Processing
When the Claims Administrator receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. Some claims take longer to process than others because they require information not provided with the claim. If additional information is requested, it must be furnished before processing of the claim can be completed.

If a Claim Is Denied or Not Paid in Full
On occasion, the Claims Administrator may deny all or part of your claim. There are a number of reasons why this may happen. First read the "Explanation of Benefits" summary prepared by the Claims Administrator; then review this Benefit Booklet to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision. Include your full name, group and subscriber numbers with the request.

Right to Review Claim Determinations
You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by the Plan of your benefits under the Plan.

If you believe all or part of your benefits were incorrectly denied and want to obtain review of its benefit determination:

1. Submit a written request for review to the Claims Administrator. Include the full name of the patient, your group and subscriber numbers, and a copy of the claim that you want reviewed.

2. Include in the written request the questions and comments you have concerning the Plan's determination.

Submit all additional information (especially medical information) that has a bearing on why you believe the determination was incorrect.

On the basis of the request as submitted, together with any other information available to it, the Plan will review its prior determination. You will be notified in writing of the Plan's determination based on this review and the reasons for it within 60 days after receiving the request for review. This determination will be final unless you provide additional information which has not previously been available for review within 60 days after receiving this final determination.

Interpretation of Plan Provisions
The Plan Administrator has full and complete authority and discretion on all Plan matters. The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions.

Therefore, the Plan Administrator has given to the Claims Administrator authority and discretion to make decisions regarding the Plan provisions and determining questions of eligibility and benefits. Any decision which is not arbitrary or capricious shall be final and conclusive.

Actions Against the Plan
No lawsuit or action in law or equity may be brought by you or on your behalf unless:

1. You first have fully complied with all of the provisions of the Plan, including all of the requirements of **Claim Filing Procedures** and **Review of Claim Determinations**; and

2. The Plan has either denied in writing your request for review of the claim determination or has not provided a written response to your request for review within 60 days after receiving the request; and

3. Such lawsuit or action is brought within three years from the expiration of the time within which written Proof of Loss is required to be furnished under the Plan.

LIMITATIONS AND EXCLUSIONS

The benefits of the Plan are not available for:

1. Any Bed-Patient Admission which commences before the patient is covered as an Employee under the Plan or after the termination of his coverage, except as provided in the ***Effect of Termination of Coverage*** Paragraph.

2. Any Bed-Patient Admission for any person acting as a donor of any organ or element of his body, unless such person is an Employee under the Plan.

3. Any Care other than a Bed-Patient Admission in a Contracting Facility or a U.S. Military Medical Treatment Facility.

4. Any day of a Bed-Patient Admission which is not Medically Necessary.

5. Custodial Care.

6. Any Bed-Patient Admission for Care which is Experimental/Investigational.

DEFINITIONS

As used in this booklet:

Actively at Work/Non-Confinement, Active Work, or **Active Service** means:

1. As applied to an Employee (other than a retired Employee), the active expenditure of time and energy in the services of the Employer at the Employee's usual and customary place of employment by an Employee who is physically and mentally capable of performing on a regular basis all of the usual and customary duties required for his position; provided, however, that an Employee shall be deemed to be so actively expending time and energy on each day of a regular paid vacation, or on a regular nonworking day, on which he is not Totally Disabled, provided he was so actively expending time and energy on the last scheduled working day preceding such vacation or nonworking day; and

2. As applied to a retired Employee, if eligible, he will not be considered to have satisfied the Actively at Work/Non-Confinement requirements if Totally Disabled.

Bed-Patient means confinement in a bed accommodation of a Facility on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed and operated to provide acute, short-term Hospital Care on a 24-hour basis; the term does not include confinement in a portion of the Hospital (other than a Facility) designed, staffed and operated to provide long-term institutional Care on a residential basis.

Medically Necessary Mental Health Care in a Psychiatric Day Treatment Facility or a Crisis Stabilization Unit or Facility, in lieu of hospitalization, shall be deemed a Bed-Patient Admission, provided each full day of treatment in such Facility shall be considered equal to one-half of one day of a special Bed-Patient Admission for Mental Health Care for calculating both the daily allowance and the number of benefit days.

Bed-Patient Admission means the period between the time of an Employee's entry into a Hospital or Facility as a Bed Patient and the time of discontinuance of bed-patient Care or discharge by the admitting Physician, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Bed-Patient Admission. If an Employee is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Bed-Patient Admission by the Claims Administrator.

Care means the services furnished by a Hospital or a Facility, prescribed by a Physician and used by the patient, which services are necessary and consistent with the sickness or injury for which the patient is being treated. The term does not include any services furnished by a Hospital (other than a Substance Abuse Facility) to ambulatory patients on a self-care basis, or an arrangement contemplating provision of only minimal services with meals to be taken outside the Hospital bedroom; provided, however, Mental Health Care in a Psychiatric Day Treatment Facility or a Crisis Stabilization Unit or Facility shall be deemed Care.

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

Claims Administrator means Blue Cross and Blue Shield of Texas, Richardson, Dallas County, Texas or any successor administrator, or an authorized representative.

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

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

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

DEFINITIONS

Eligibility Date means the date the applicant satisfies the definition of Employee and is in a class eligible for coverage under the Plan as described in **Who Gets Benefits** in this Benefit Booklet.

Emergency Care means health care services provided in a Hospital emergency facility (emergency room) or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

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

Employee means a person who regularly provides personal services at the Employee's usual and customary place of employment with the Employer for not less than 120 hours per month in the business of the Employer, and who is duly recorded as such on the payroll records of the Employer and is compensated for such services by salary or wages; except that proprietors, partners, corporate officers and directors need not be compensated for such services by salary or wages.

If the Employer has elected to cover Retired Employees, the term "Employee" shall also include those persons who are considered Retired Employees under the Employer's established procedures whereby individual selection by the Employer or the Employee to be included in the retired Employee classification is precluded.

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

Employer means, in addition to the person, firm or institution named on the front cover of this Benefit Booklet, one or more subsidiaries or affiliates, if any, listed in the Plan.

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

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

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

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

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

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

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

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

Facility means a Crisis Stabilization Unit or Facility, a Psychiatric Day Treatment Facility, a Substance Abuse Facility, or any other facility which is appropriately licensed and accredited, and which furnishes Care to an Employee as described in the "Benefits Provided" Section of this booklet.

Hospital means a short-term acute Care facility which:

1. Is duly licensed as a hospital by the state in which it is located and meets the standards established for such licensing, and is either accredited by the Joint

Commission on Accreditation of Health Care Organizations or is certified as a hospital provider under Medicare;

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

3. Has organized departments of medicine and major surgery and maintains clinical records on all patients;

4. Provides 24-hour nursing services by or under the supervision of Registered Nurses;

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

6. Is not, other than incidentally, a skilled nursing facility, nursing home, custodial care home, health resort, spa or sanitarium, place for rest, place for the aged, place for the treatment of Chemical Dependency, hospice, place for the provision of rehabilitative care, or a place for the treatment of pulmonary tuberculosis.

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

a. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction; and

b. Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and

c. Not primarily for the convenience of the Participant, his Physician, the Hospital or the Other Provider; and

d. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

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

Member Hospital means any Hospital located in the State of Texas which is a Contracting Facility and which has executed a written member hospital contract with the Claims Administrator for the provision of certain categories of care, services, and supplies for which benefits are provided by the Plan.

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

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

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

   1. Individual, group, family or conjoint psychotherapy,

   2. Counseling,

   3. Psychoanalysis,

   4. Psychological testing and assessment,

   5. The administration or monitoring of psychotropic drugs, or

   6. Hospital visits or consultations in a facility listed in subsection e, below;

c. Electroconvulsive treatment;

d. Psychotropic drugs;

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

Noncontracting Facility means a Hospital, a Facility, or any other facility or institution which has not executed a written contract with the Claims Administrator for the provision of Care for which benefits are provided by the Plan. Any Hospital, Facility, or any other facility or institution with a written contract with the Claims Administraor which has expired or has been canceled is a Noncontracting Facility.

Nonmember Hospital means any Hospital located in the State of Texas which is a Contracting Facility and has executed a written nonmember hospital contract with the Claims Administrator for the provision of certain categories of Care for which benefits are provided by the Plan.

Period of Bed-Patient Confinement means the combination of any number of Hospital or Facility admissions of an Employee until there is an interval of at least 90 days free of bed-patient Care between any two consecutive admissions in either a Hospital or a Facility.

Physician means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy.

Plan Administrator means the person, persons, or firm designated by the Employer to be responsible for the day-to-day functions and management of the Plan.

Plan Effective Date means the date on which coverage under the Plan commences for the Employer.

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

Plan Year means the calendar, policy or fiscal year on which the records of the plan are kept. The Plan Year for Willis ISD is September 1 through August 31.

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

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

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

a. bipolar disorders (hypomanic, manic, depressive, and mixed);

b. depression in childhood and adolescence;

c. major depressive disorders (single episode or recurrent);

d. obsessive-compulsive disorders; and

e. paranoid and other psychotic disorders;

f. pervasive developmental disorders;

g. schizo-affective disorders (bipolar or depressive); and

h. schizophrenia.

Substance Abuse Facility means an institution located in the State of Texas which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which institution is also:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral; or

2. Accredited as such an institution by the Joint Commission on Accreditation of Health Care Organizations; or

3. Licensed, certified, or approved as a Chemical Dependency treatment program or center by any agency of the State of Texas having legal authority to so license, certify or approve.

Any Substance Abuse Facility located outside the State of Texas shall be licensed, certified, or approved as a Chemical Dependency treatment center by the appropriate agency of the state in which it is located and be accredited as such an institution by the Joint Commission on Accreditation of Health Care Organizations.

Total Disability or **Totally Disabled** means:

1. As applied to an Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of his occupation and any other gainful occupation in which the Employee

earns substantially the same compensation earned prior to disability; and

2. As applied to a retired Employee, the complete inability of the retired Employee to carry on all of the normal duties or activities of a person in good health who is the same sex and approximate age.

GENERAL INFORMATION

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If the Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

1. The Plan Sponsor will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.

2. The Claims Administrator will furnish the Plan Sponsor with this Benefit Booklet as a description of benefits available under this Plan. Upon written request by the Plan Sponsor, the Claims Administrator will send any information which the Claims Administrator has that will aid the Plan Sponsor in making its annual reports.

3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Plan. Claim filing and claim review health procedures are found in the **How to Receive Benefits** section of this Benefit Booklet.

4. BCBSTX, as the Claims Administrator, is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Plan.

5. This Benefit Booklet is not a Summary Plan Description.

6. The Plan Sponsor has given the Claims Administrator the authority and discretion to interpret the Plan provisions and to make eligibility and benefit determinations.

REFUND OF BENEFIT PAYMENTS

If the Plan pays benefits for Care provided to you and it is found that the payment was more than it should have been, or was made in error, the Plan has the right to a refund from you, any other insurance company, or any other organization. If no refund is received, the Plan may deduct any refund due it from any future benefit payment.

TERMINATION OF COVERAGE

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

Termination of Individual Coverage

Coverage under the Plan for you will automatically terminate when:

1. Your contribution for coverage under the Plan is not received timely by the Plan Administrator; or

2. Your employment terminates; or

3. The Plan is amended to terminate the coverage of the class of Employees to which you belong; or

4. A Dependent ceases to be a Dependent as defined in the Plan.

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

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

1. *Disabled,* and

2. Dependent upon you for more than one-half of his support as defined by the Internal Revenue Code of the United States.

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

Termination of the Group

The coverage of all Participants will terminate if the group is terminated in accordance with the terms of the Plan. However, see **Continuation of Group Coverage**, below.

GENERAL INFORMATION

CONTINUATION OF GROUP COVERAGE

The following events **may** provide an option to continue group coverage for you:

- The termination of your status as an Employee (except for reason of gross misconduct) or retirement;
- If you are covered as a retired Employee, the filing of a Title XI bankruptcy proceeding by the group.

If such an event occurs, you should immediately contact your Employer to determine your rights. Also, refer to the *Important Notice to Employees and Dependents of Continuation Option* (COBRA) at the end of this Benefit Booklet.

If the occurrence of the event requires coverage to terminate and if there is a right to continue the group coverage, the election to do so must be made within 60 days. You may be required to pay your own contribution rates. Any continued coverage will be identical to that of similarly situated members of the group, including any changes (see your Schedule of Coverage). Hence, changes in the group contribution rates or benefits will change the contribution rates or benefits for any continued coverage.

The continued coverage automatically terminates after a period of time (never to exceed three years) but will be terminated earlier upon the occurrence of certain circumstances. These circumstances include, but are not limited to, nonpayment of contributions and coverage under any other group coverage which does not contain a limitation with respect to a Preexisting Condition of the Participant (even if such coverage is less valuable than your current health plan). Your Employer will give you more detailed information upon your request.

AMENDMENTS

The Plan may be amended or changed at any time by a written agreement between the Employer. No notice to or consent by any Employee is necessary to amend or change the Plan.

NOTICES

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS

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

HOW IS COBRA COVERAGE PROVIDED?

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

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

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

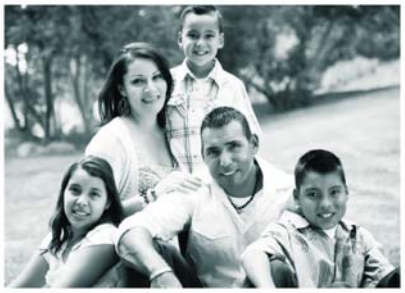
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

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

AMENDMENTS

BlueCross BlueShield of Texas



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