

EXHIBIT B

EMPLOYEE BENEFIT PLAN

(herein referred to as the "Plan")

MASTER BENEFIT PLAN DOCUMENT

describing the

HEALTHSELECT OF TEXASSM

COMPREHENSIVE MEDICAL CARE PLAN

(Out of Area Benefits)

for the

EMPLOYEES RETIREMENT SYSTEM OF TEXAS

(herein referred to as "ERS")

Plan Effective Date: September 1, 2003

Account Number 38000-B

**NOTICE OF ELECTION OF EXEMPTION UNDER THE HEALTH INSURANCE PORTABILITY
AND ACCOUNTABILITY ACT OF 1996**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans as follows:

1. Limitations on preexisting conditions exclusion periods;
2. Special enrollment periods for individuals (and dependents) losing other coverage;
3. Prohibitions against discriminating against individual participants and beneficiaries based on health status;
4. Standards relating to benefits for mothers and newborns;
5. Parity in the application of certain limits to behavioral health benefits; and
6. Required coverage for reconstructive surgery following mastectomies.

However, HIPAA permits certain government group health plans the right of exemption from certain provisions of this federal law. For the plan year beginning September 1, 2003 through August 31, 2004, the Employees Retirement System of Texas (ERS) has elected to exempt HealthSelect of Texas (HealthSelect) from HIPAA provisions 2 and 3 above. Therefore, employees and retirees who do not enroll themselves and their dependents in HealthSelect during their initial period of eligibility may be subject to evidence of insurability requirements if they wish to enroll at a later date.

Article I – Definitions

Accidental Injury..... 1

Act..... 1

Active Employee..... 1

Actively at Work, Active Work, Active Service, or Active Duty 1

Adverse Determination 1

Allowable Amount..... 1

Ambulance Service 2

Ambulatory Day Surgery Facility 2

Annuitant..... 2

Basic Coverage..... 2

Behavioral Health Care..... 3

Behavioral Health Provider..... 3

Benefits Coordinator 4

Bundling..... 4

Calendar Year..... 4

Claims Administrator 4

Clinical Ecology..... 4

Coinsurance..... 4

Committee..... 4

Complications of Pregnancy 4

Copayment 4

Cosmetic, Reconstructive, or Plastic Surgery 5

Covered Oral Surgery 5

Covered Services and Supplies 5

Crisis Stabilization Unit or Facility..... 5

Custodial Care..... 5

Deductible 5

Dental Care Services 5

Dependent 6

Diabetes Equipment 6

Diabetes Self-Management Training Programs 6

Diabetes Supplies..... 6

Diabetic Management Services..... 7

Dietary and Nutritional Services..... 7

Durable Medical Equipment 7

Durable Medical Equipment Provider..... 7

Effective Date..... 7

Emergency 7

Employee 7

Employer..... 7

Employing Office..... 8

Environmental Sensitivity..... 8

Evidence of Insurability 8

Experimental And Investigational..... 8

Extended Care Services..... 8

Facility 8

Family Deductible..... 9

Full-Time Employee 9

Fund 9

HMO 9

Home Health Agency..... 9

Home Health Care..... 9

Home Infusion Therapy	9
Home Infusion Therapy Provider.....	10
Hospice.....	10
Hospice Care	10
Hospital	10
Hospital Admission.....	10
Imaging Center.....	11
Immediate Family Member.....	11
Independent Laboratory	11
Infertility Services.....	11
Inpatient	11
Inpatient Care.....	11
Inpatient Copayment.....	11
Inpatient Copayment Maximum.....	11
Inpatient Hospital Expense.....	11
INROADS®	12
Marriage and Family Therapy/Counseling.....	12
Maternity Care	12
Medical Social Services	12
Medically Necessary or Medical Necessity	12
Office Visit.....	13
Other Medical Expense	13
Out-of-Pocket Coinsurance Maximum	15
Outpatient.....	15
Outpatient Care	15
Outpatient Day-Surgery Copayment.....	15
Outpatient Hospital Expense.....	15
ParPlan Provider.....	15
Participant	15
Part-Time Employee	15
Physician.....	16
Plan Administrator	16
Plan Anniversary.....	16
Plan Effective Date	16
Plan Month.....	16
Plan Service Area.....	16
Plan Year.....	16
Preadmission Testing Services.....	16
Preauthorization	16
Predetermination	17
Private-Duty Nurse.....	17
Private-Duty Nursing	17
Program.....	17
Proof of Loss.....	17
Prosthetic Appliances.....	17
Prosthetics Provider	18
Provider.....	18
Psychiatric Day Treatment Facility.....	19
Psychiatric Intermediate Care Facility	19
Renal Dialysis Center.....	19
Residential Treatment Center for Children and Adolescents	19
Retiree	19
Routine Eye Exam.....	19
Routine Foot Care	19

Rule or Rules.....	20
Rural Health Clinic	20
Schedule	20
Serious Mental Illness	20
Skilled Nursing Facility	20
State Agency	21
Subscriber Identification Number (Subscriber ID)	21
Substance Abuse (Chemical Dependency).....	21
Substance Abuse Facility	21
Telemedicine Services	21
Therapeutic Center.....	21
Total Disability or Totally Disabled.....	21
Trustee.....	22
Article II – Eligibility for Coverage; Effective Dates	
Eligibility for Coverage.....	23
Application for Coverage.....	23
Effective Dates – Timely Applications	23
Effective Dates – Late Applications.....	23
Plan Service Area.....	24
Employees Over Age 65 and Retirees.....	24
Article III – Payment of Benefits; Participant/Provider Relationship; Coordination of Benefits	
Payment of Benefits	26
Participant/Provider Relationship	27
Coordination of Benefits.....	27
Article IV – Benefits Provided	
Benefits for Inpatient Hospital Expense.....	32
Benefits for Other Medical Expense	33
Benefits for Extended Care-Services and Home Infusion Therapy	33
Deductibles and Copayment Amounts	34
Other Benefit Provisions	
Treatment of Complications of Pregnancy	35
Maternity Care	35
Newborn Well-Baby Care.....	35
Serious Mental Illness.....	36
Behavioral Health Care.....	36
Treatment of Substance Abuse (Chemical Dependency).....	37
Mammography Screening	38
Hearing Aids	38
Diabetic Management Services.....	38
Dental Care Services	38
Routine Physical Exams.....	38
Routine Eye Exams	39
Organ and Tissue Transplants.....	39
Prostate Screening and Cancer Detection Services.....	40
Telemedicine Services.....	40
Childhood Immunizations	40
Ambulance Services.....	41
Bone Mass Measurement Services.....	41
Colorectal Cancer Screening.....	41
Treatment of Acquired Brain Injury.....	42
Infertility Services	42

Skilled Nursing Facility Benefits	42
Home Health Care Benefits.....	43
Hospice Care Benefits.....	44
Private Duty Nursing Benefits	45
Case Management	46
Blue Card Worldwide	47
Coinsurance Stop-Loss; Maximum Lifetime Benefits	47
Medical Necessity	48
Article V – Limitations and Exclusions	49
Article VI – Termination of Coverage	54
Article VII – Extension of Benefits.....	56
Article VIII – Option to Continue Group Coverage and Conversion Privilege.....	57
Article IX – General Provisions	
Applicable Law	58
Claim Denial and Appeal	58
Claim Forms.....	59
Copies; Plan Information	59
Coverage Data.....	59
Disclaimer	59
Disclosure Authorization.....	59
Funding	60
Gender.....	60
Legal Actions	60
Master Benefit Plan Document; Amendments	60
Medicare/Primary Carrier Determinations	60
Not a Contract	60
Notice of Claim	60
Physical Examinations and Autopsy	61
Proof of Loss.....	61
Refund of Benefit Payments	61
State Government Programs.....	61
State or Federal Law	61
Subrogation	62
Time of Payment of Claims	63
Workers’ Compensation Insurance	63
Schedule of Specifications	64
Plan Effective Date	68

Article I Definitions

As Used Herein:

- A. **Accidental Injury** means accidental bodily injury resulting, directly and independently of all other causes, in care provided by a Provider within 48 hours after the occurrence.
- B. **Act** means the Texas Employees Group Benefits Act (Chapter 1551 of the *Texas Insurance Code*).
- C. **Active Employee** means an Employee as defined in the Act.
- D. **Actively at Work, Active Work, Active Service or Active Duty** means the active expenditure of time and energy in the service of the Employer, except for elected officials of the State who qualify under the Act. An Employee will be considered to be on Active Duty on each day of a regular paid vacation or regular paid sick leave, or on a regular non-working day, provided he was Actively at Work on the last preceding working day.
- E. **Adverse Determination** means a determination by BCBSTX that the health care services proposed to be furnished to a Participant are not Medically Necessary.
- F. **Allowable Amount** means the actual charge, or portion thereof, for a service or supply to the extent such service or supply is reasonably priced based on the illness or injury being treated.

A Provider's charge is allowable if (based on the data base compiled by the Claims Administrator) it falls within the range of the charges for similar services or supplies customarily made by Providers of health care services with similar training, experience, and facilities in the region as defined by the Claims Administrator. Regions, for this purpose, need not be composed of contiguous geographical areas and will be located only in the state of Texas.

In the case of multiple surgeries through the same incision or operative area for which there is not a unique, single procedure code, the Allowable Amount will be determined by combining the amount equal to the highest single procedure Allowable Amount of the procedures performed with one-half of the Allowable Amount for each of the other procedures performed.

For certain Providers contracting with the Claims Administrator, Allowable Amount is based on the provisions of the Provider contract and the payment methodology in effect on the date of service, whether Diagnostic Related Grouping (DRG), capitation, relative value, fee schedule, or other.

For Providers not contracting with the Claims Administrator, Allowable Amount shall be based on the amount which would have been paid for the same covered service, supply, or procedure with an equivalent contracting Provider.

When the Claims Administrator has an insufficient data base (less than three charge detail of different providers) to determine the Allowable Amount within the range of charges or there is no procedure code for the particular service or supply, the Claims Administrator shall determine the Allowable Amount for a service or supply by "manual pricing." A Provider's charge for the procedure is allowable to the extent it does not exceed the manual pricing methodology determined by the Claims Administrator to be the most appropriate.

Article I Definitions (Continued)

The Claims Administrator will utilize one of the following methodologies to determine Allowable Amount by manual pricing as determined by the Claims Administrator to be the most appropriate to the procedure involved:

1. Cumulative charge is the Allowable Amount for all the component parts of a procedure(s) as if it were multiple surgeries through the same incision or operative area; or
2. Analogous charge is the Allowable Amount for an analogous procedure (similar in complexity) with a procedure code and a sufficient data base to determine the range of charges; or
3. Corresponding value is the Allowable Amount determined by utilizing a relative value for the service or procedure multiplied by a conversion factor (in dollars) for the service or procedure.

The relative value of a procedure will be based on the complexity of the procedure or service and is derived from a “difficulty” ranking system for comparable procedures. The conversion factor will be determined by compiling charge information for each type of service in the specialty and locality for the data period and dividing by the total number of procedures from which the charge information has been compiled; or

4. The Allowable Amount determined by Blue Cross and Blue Shield Plans in other states where such procedure is more common and a procedure code and sufficient data base exists.

In making a determination of the Provider’s Allowable Amount, the Claims Administrator shall consider unusual circumstances or medical complications requiring additional time, skill, experience, and facilities in connection with a particular service, which are specifically brought to the Claims Administrator’s attention. The Claims Administrator will evaluate the data base for the Allowable Amount determination on an annual basis to determine the need for adjustment.

In the event the foregoing bases for establishing the Allowable Amount are inapplicable, the Claims Administrator may determine the Allowable Amount through other methodologies on a reasonable basis.

- G. **Ambulance Service** means professional local ground ambulance or air ambulance transportation services to the nearest Hospital or Facility appropriately equipped and staffed for treatment of the Participant’s condition.
- H. **Ambulatory Day Surgery Facility** means a Therapeutic Center which is a public or private institution, a separate wing or unit of a Hospital, a Hospital-based surgery center, freestanding or Hospital-affiliated clinic or ambulatory surgery center, a Hospital-affiliated birthing center, or a freestanding birthing center operated by a licensed Provider and certified nurse-midwives; provided such center is licensed by the Texas Department of Health and contracts with the Claims Administrator as a Therapeutic Center or is shown by the Participant to otherwise meet all requirements of an Ambulatory Day Surgery Facility.
- I. **Annuitant** means a person as defined in the Act.
- J. **Basic Coverage** means the program of group health coverage determined by the Trustee, either the Managed Care Plan or the Comprehensive Medical Care Plan, whichever is applicable, in which every full-time Employee or Retiree is automatically enrolled, unless participation is specifically waived.

Article I Definitions (Continued)

- K. **Behavioral Health Care** means any one or more of the following:
1. The diagnosis or treatment of a mental disease, disorder, or condition as defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual (DSM) IV*, or any other diagnostic coding system as used by the Claims Administrator, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin;
 2. The diagnosis or treatment of any symptom, condition, disease or disorder by a Physician or Other Provider (or by any person working under the direction or supervision of a Physician or Other Provider) when the Covered Service or Supply is:
 - a. Individual, group, family, or conjoint psychotherapy,
 - b. Counseling,
 - c. Psychoanalysis,
 - d. Psychological testing and assessment,
 - e. The administration or monitoring of psychotropic drugs, or
 - f. Hospital visits or consultations in a Facility listed in Subsection 5, below;
 3. Electroconvulsive treatment;
 4. Psychotropic drugs;
 5. Any of the services listed in Subsections 1 through 4, above, performed in or by a Hospital, Psychiatric Intermediate Care Facility, or other licensed Facility or unit providing such care.
- L. **Behavioral Health Provider** means providers who provide services for behavioral health care. Benefits are available only when the licensed providers are providing services and/or supplies within the scope of their license. Providers include:
- Licensed Master Social Worker-Advanced Clinical Practitioner
 - Doctor of Psychology (certified as a health care provider)
 - Licensed Marriage and Family Therapist
 - Licensed Professional Counselor
 - Licensed Chemical Dependency Counselor
 - Licensed Psychological Associate

In states where there is a license requirement, Behavioral Health Providers must be licensed by the appropriate state administrative agency. These providers must also meet state licensing requirements comparable to those applicable in the state of Texas in order to receive benefits under the Plan, regardless of whether services are provided in the state of Texas.

Benefits are available for services provided by providers included in this definition or as referenced in the definition of Other Medical Expense.

Article I Definitions (Continued)

- M. **Benefits Coordinator** means the person employed by the State Agency, college, or university who can provide assistance to Participants who are enrolling in various benefit plans or changing their coverage. For Retirees, this assistance is provided by ERS.
- N. **Bundling** means the process that identifies a medical procedure that is incidental to another billed procedure, and is therefore included in that charge and not eligible for separate benefits.
- O. **Calendar Year** means the period commencing on a January 1 and ending on the next succeeding December 31, inclusive.
- P. **Claims Administrator** means Health Care Service Corporation, a Mutual Legal Reserve Company, which does business in Texas as Blue Cross and Blue Shield of Texas (BCBSTX), a Division of Health Care Service Corporation.
- Q. **Clinical Ecology** means the inpatient or outpatient diagnosis or treatment of allergic symptoms by:
1. Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells); or
 2. Urine auto injection (injecting one's own urine into the tissue of one's own body); or
 3. Skin irritation by Rinkel method; or
 4. Sublingual provocative testing (placing of allergenic extracts in one's mouth); or
 5. Any other method not recognized as safe and effective by the American Academy of Allergists and Immunologists.
- R. **Coinsurance** means the cumulative dollar amount of Covered Services and Supplies incurred by a Participant during a Calendar Year to be applied toward the Out-of-Pocket Coinsurance Maximum.
- S. **Complications of Pregnancy** means:
1. Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy. Services and supplies provided at termination of pregnancy shall not be considered treatment of Complications of Pregnancy as defined in this Subsection 1.
 2. Termination of pregnancy by nonelective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.
- T. **Copayment** means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for certain services at the time they are provided.

Article I Definitions (Continued)

- U. **Cosmetic, Reconstructive, or Plastic Surgery** means surgery that:
1. Can be expected or is intended to improve the physical appearance of a Participant, but does not correct or materially restore a bodily function; or
 2. Is performed for psychological purposes; or
 3. Restores form but does not correct or materially restore a bodily function.
- V. **Covered Oral Surgery** means maxillofacial surgical procedures limited to:
1. Excision of neoplasms, including benign, malignant and premalignant lesions, tumors and cysts;
 2. Incision and drainage of cellulitis;
 3. Surgical procedures involving accessory sinuses, salivary glands and ducts;
 4. Reduction of a dislocation of, excisions of, and injection of the temporomandibular joint, excluding all oral appliances and devices used to diagnose and/or treat temporomandibular pain disorders or dysfunction of the joint and related structures, such as the jaws, jaw muscles and nerves (does not include any type of correction of the occlusion of the teeth to eliminate temporomandibular joint pain or dysfunction or related appliances);
 5. Correction of damage caused by external violent accidental injury to healthy natural teeth, if the accident occurs while the Participant is covered under HealthSelect. Services must be received within 24 months from the date of the accident;
 6. Orthognathic surgery.
- W. **Covered Services and Supplies** means either Inpatient Hospital Expense, Other Medical Expense, or Extended Care Services, all as specified in the Plan.
- X. **Crisis Stabilization Unit or Facility** means an institution which is appropriately licensed and accredited and approved by the Claims Administrator as a Crisis Stabilization Unit or Facility for the provision of certain categories of Behavioral Health Care and Serious Mental Illness services to persons who are exhibiting an acute demonstrable psychiatric crisis of moderate to severe proportions.
- Y. **Custodial Care** means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury. "Custodial Care" is care which is not a necessary part of medical treatment for recovery, and shall include, but not be limited to, helping a Participant walk, bathe, dress, eat, prepare special diets, and take medication.
- Z. **Deductible** means the dollar amount of Covered Services and Supplies that must be incurred by a Participant before benefits under the Plan will be available.
- AA. **Dental Care Services** means the professionally recognized dental services, supplies, or appliances which are provided to a Participant by a Physician or Other Provider when acting within the scope of his license who is a Doctor of Dentistry (D.D.S. or D.M.D. degree) and shall also include a person who is a Doctor of Medicine or a Doctor of Osteopathy. Dental Care Services include, but are not limited to, cleaning, filling of teeth, crowns (or capping), root canals, restoration, replacement or repositioning of teeth, or alteration of the alveolar or periodontium processes of the maxilla and the mandible.

Article I Definitions (Continued)

AB. **Dependent** means the spouse of an Employee or Retiree or any unmarried child who is either under 25 years of age or disabled; provided that in the case of a disabled child 25 years of age or older, such child is dependent upon the Employee or Retiree for care or support.

“Child” means a child as defined in the Act and whose eligibility requirements are stated in the Rules of the Board of Trustees of ERS.

“Disabled” means the presence of any medically determinable physical or mental condition which prevents the child from engaging in self-sustaining employment; provided that the disability commences and the child was covered immediately prior to such child’s attainment of age 25 and that satisfactory proof of such disability and dependency is submitted by the Employee or Retiree within 31 days following such child’s attainment of age 25 and at such intervals thereafter as may be required by ERS.

AC. **Diabetes Equipment** means:

1. Blood glucose monitors, including monitors designed to be used by blind individuals;
2. Insulin pumps and associated appurtenances;
3. Insulin infusion devices; and
4. Podiatric appliances for the prevention of complications associated with diabetes.

AD. **Diabetes Self-Management Training Programs** include:

1. Training provided after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;
2. Additional training provided after a diagnosed significant change in symptoms or condition that requires changes in the self-management regime; and
3. Periodic or episodic continuing education training as warranted by the development of new techniques and treatments for diabetes.

AE. **Diabetes Supplies** means:

1. Test strips for blood glucose monitors;
2. Visual reading and urine test strips;
3. Lancets and lancet devices;
4. Insulin and insulin analogs;
5. Injection aids;
6. Syringes;
7. Prescriptive and nonprescriptive oral agents for controlling blood sugar levels;

Article I Definitions (Continued)

8. Glucagon emergency kits; and
 9. Alcohol wipes.
- AF. **Diabetic Management Services** include Diabetes Equipment, Diabetes Supplies and Diabetes Self-Management Training Programs, which are rendered by or at the direction of a Physician.
- AG. **Dietary and Nutritional Services** means the education, counseling, or training of a Participant (including printed material) regarding:
1. Diet;
 2. Regulation or management of diet; or
 3. The assessment or management of nutrition.
- AH. **Durable Medical Equipment** means supplies and equipment required for therapeutic or rehabilitative use by the Participant, such as a wheelchair, hospital-type bed, artificial respirator, or similar equipment. Equipment designed for alleviation of pain or provision of patient comfort (for example, motorized lifts, air conditioners, humidifiers, air purifiers, dehumidifiers, physical fitness and whirlpool bath equipment, home air fluidized beds, mattresses, allergen-free pillows, personal hygiene protection, blood pressure cuffs, and over-the-counter splints and braces) is not covered, even if prescribed by the patient's Provider.
- AI. **Durable Medical Equipment Provider** means a Provider that provides Durable Medical Equipment and is accredited by the Joint Commission on Accreditation of Health Care Organizations.
- AJ. **Effective Date** means the date the Participant's coverage begins under the Plan.
- AK. **Emergency** means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his condition, sickness or injury is of such a nature that failure to get immediate medical care could reasonably result in:
1. Placing the Participant's health in serious jeopardy; or
 2. Serious impairment to bodily functions; or
 3. Serious dysfunction of any bodily organ; or
 4. Serious disfigurement; or
 5. In the case of a pregnant woman, serious jeopardy to the health of the fetus.
- The Claims Administrator determines if a medical condition is an Emergency based on factors which include medical information supplied by the patient's Provider.
- AL. **Employee** means any appointive or elective State officer or employee in the service of the state of Texas, including an employee of an institution of higher education, as defined in Section 1551.003(6) *Texas Insurance Code*.
- AM. **Employer** means the state of Texas and all its Agencies, as State Agency is defined in the Act.

Article I Definitions (Continued)

- AN. **Employing Office** means, for a Retiree covered by this Program, the office of the Employees Retirement System in Austin, Texas or the Retiree's last employing State Agency; for an Active Employee, the Employee's employing State Agency.
- AO. **Environmental Sensitivity** means the inpatient or outpatient setting treatment of allergic symptoms by:
1. Controlled environment; or
 2. Sanitizing the surroundings, removal of toxic materials; or
 3. Use of special nonorganic, nonrepetitive diet techniques.
- AP. **Evidence of Insurability** means such evidence of the condition of one's health, including medical records and a physical examination, as may be required by the Claims Administrator for changes in existing coverage or issuance of new coverage pursuant to the Rules of the Board of Trustees of the Employees Retirement System of Texas.
- AQ. **Experimental and Investigational** means a drug, device, equipment, facility, procedure, or treatment that is not generally accepted as standard medical treatment of the condition being treated, or any such items requiring Federal or other governmental agency approval, if such approval has not been granted at the time services are provided.
- AR. **Extended Care Services** means the services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, a Hospice, or a Private-Duty Nurse as described in Article IV, Sections F, G, H and I, of the Plan.
- AS. **Facility** means an institution that is licensed where required to provide an item of service or supply described herein as Covered Medical Expense. Facilities shall include:
1. Durable Medical Equipment Provider
 2. Home Health Agency
 3. Home Infusion Therapy Provider (must be under contract with BCBSTX or accessible through BlueCard[®] Worldwide)
 4. Hospice
 5. Imaging Center
 6. Independent Laboratory
 7. Prosthetics Provider
 8. Psychiatric Intermediate Care Facility
 9. Renal Dialysis Center
 10. Rural Health Clinics (must be under contract with BCBSTX or accessible through BlueCard Worldwide)

Article I Definitions (Continued)

11. Skilled Nursing Facility
 12. Substance Abuse Facility
 13. Therapeutic Center
 14. Spiritual Care Facility
- AT. **Family Deductible** means a Deductible amount that is satisfied when three individuals in the same family that are covered under one Subscriber Identification Number each meet their Calendar Year Deductible. When that Family Deductible amount is reached, no further individual Deductibles will have to be satisfied for that Calendar Year.
- AU. **Full-Time Employee** means an Employee as defined by Section 1551.003(9) in the Act.
- AV. **Fund** means the Employees' Life, Accident and Health Insurance and Benefits Fund created by the Act which is administered by the Trustee.
- AW. **HMO** means a Health Maintenance Organization approved by the ERS Board of Trustees to provide health care benefits to Participants in the Texas Employees Group Benefits Program in lieu of participation in such Program's self-funded health benefits plan.
- AX. **Home Health Agency** means an entity that is primarily engaged in providing Home Health Care and which:
1. Is licensed in accordance with state law; and
 2. Is certified by Medicare as a supplier of Home Health Care.
- AY. **Home Health Care** means the health care services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a sickness or injury requiring skilled health care services on an intermittent, part-time basis.
- AZ. **Home Infusion Therapy** means the administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:
1. Drugs and IV solutions;
 2. Pharmacy compounding and dispensing services;
 3. All equipment and ancillary supplies necessitated by the defined therapy;
 4. Delivery services;
 5. Patient and family education;
 6. Nursing services.

Article I Definitions (Continued)

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

- BA. **Home Infusion Therapy Provider** means an entity that is duly licensed by the appropriate state agency to provide Home Infusion Therapy and has contracted with the Claims Administrator or accessible through BlueCard Worldwide as a provider of Home Infusion Therapy.
- BB. **Hospice** means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which:
1. Is licensed in accordance with state law (where the state law provides for such licensing); and
 2. Is certified by Medicare as a supplier of Hospice Care.
- BC. **Hospice Care** means services for which benefits are provided under the Plan when provided by a Hospice to patients confined at home or in a Hospice facility due to a terminal sickness or terminal injury requiring skilled health care services.
- BD. **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 alcohol abuse or drug abuse, hospice, place for the provision of rehabilitative care, or a place for the treatment of pulmonary tuberculosis.
- BE. **Hospital Admission** means the period between the time of a Participant's entry into a Hospital or Substance Abuse Facility as a bed patient and the time of discontinuance of bed-patient Hospital care or discharge by the admitting Physician or Other Provider, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Hospital Admission. If a Participant is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed patient in a bed accommodation during the period of time he is confined in the Hospital, the admission shall be considered a Hospital Admission by the Claims Administrator.

"Bed patient" means confinement in a bed accommodation of a Substance Abuse Facility on a 24-hour basis or in a bed accommodation located in a portion of a Hospital which is designed, staffed, and

Article I Definitions (Continued)

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 Substance Abuse Facility) designed, staffed and operated to provide long-term institutional care on a residential basis.

- BF. **Imaging Center** means a Facility that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Texas State Radiation Control Agency.
- BG. **Immediate Family Member** means a person related by blood or marriage who is a spouse, parent, child, mother-in-law, father-in-law, brother, sister, brother-in-law, sister-in-law, aunt, uncle, niece, nephew, cousin, grandparent or grandchild.
- BH. **Independent Laboratory** means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.
- BI. **Infertility Services** means the diagnosis and treatment of involuntary infertility. These services may include diagnostic laboratory and x-ray procedures, therapeutic injections and surgical treatment. Covered services do not include sterilization reversal, transsexual surgery, gender reassignment, artificial insemination and related services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures.
- BJ. **Inpatient** means a Participant who has been admitted to a Hospital or a Substance Abuse Facility for 24 or more consecutive hours.
- BK. **Inpatient Care** means care provided to an Inpatient.
- BL. **Inpatient Copayment** means the copayment amount a Participant pays per day for an Inpatient Hospital admission.
- BM. **Inpatient Copayment Maximum** means the total amount that a Participant must pay in Inpatient Copayments in a Calendar Year (excluding copayments for outpatient day-surgery and prescription drugs) before the Participant no longer must pay the Inpatient Copayment. Inpatient Psychiatric and Intermediate copayments apply to this Inpatient Copayment Maximum.
- BN. **Inpatient Hospital Expense** means charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant; provided that such items are:

1. Furnished at the direction or prescription of a Physician or Other Provider; and
2. Provided by a Hospital or a Substance Abuse Facility; and
3. Furnished to and used by the Participant during a Hospital Admission.

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

1. Room accommodation charges. If the Participant is in a private room, the amount of the room charge in excess of the Hospital's average semiprivate room charge is not an eligible expense.
2. All other usual Hospital services which are Medically Necessary and consistent with the condition of the Participant. Personal items are not an eligible expense.

Article I Definitions (Continued)

Medically Necessary Behavioral Health Care or treatment of Serious Mental Illness in a Psychiatric Intermediate Care Facility, in lieu of hospitalization, shall be Inpatient Hospital Expense.

- BO. **INROADS®** refers to INROADS Behavioral Health Services of Texas, L.P., a Magellan Behavioral Health Company. Further, it means a utilization management unit operated by the Claims Administrator for the purpose of referring, coordinating, and preauthorizing all Inpatient Network and Non-Network Behavioral Health Care, Serious Mental Illness, and Substance Abuse Conditions (Chemical Dependency) benefits under the Plan.
- BP. **Marriage and Family Therapy/Counseling** means the provision of professional therapy services to individuals, families, or married couples, singly or in groups, and involves the professional application of family systems theories and techniques in the delivery of therapy services to those persons. The term includes the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction within the context of marriage or family systems.
- BQ. **Maternity Care** means prenatal and postnatal care and delivery services provided by the delivering physician for diagnosis and treatment of the condition of pregnancy, other than Complications of Pregnancy, sonograms, stress tests, amniocentesis, lab fees, tubal ligation, circumcision, assistant surgeon fees, anesthesiologist fees, and Inpatient Hospital Expenses.
- BR. **Medical Social Services** means those social services relating to the treatment of a Participant's medical condition. Such services include, but are not limited to:
- (1) Assessment of the social and emotional factors related to the Participant's sickness, need for care, response to treatment and adjustment to care; and
 - (2) Assessment of the relationship of the Participant's medical and nursing requirements to the home situation, financial resources, and available community resources.
- BS. **Medically Necessary** or **Medical Necessity** means those services or supplies covered under the Plan which, as determined by the Claims Administrator, are:
1. Consistent with, appropriate to, and provided for the diagnosis or the direct care and treatment of the condition, illness, disease, or injury; and
 2. Not primarily for the convenience of the Participant or Provider, and
 3. The most economical care or levels of service that are appropriate and available 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; and
 4. Consistent with standards of good medical practice; and
 5. Not Experimental/Investigational in nature at the time services or supplies are provided.

In determining whether the use of any treatment, procedure, facility, equipment, drug, device, or supply is Medically Necessary, as that term is defined above, the Claims Administrator shall consider the views of the State and national medical associations, published articles and studies and other medical literature, and the views and practices of Medicare, Medicaid or other government-financed

Article I Definitions (Continued)

programs. The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, of itself, make it Medically Necessary or make the charge a Covered Service or Supply, even though it is not specifically listed as an exclusion.

The authority of the Claims Administrator to determine Medical Necessity is subject to the right of the Board of Trustees, in a contested case, to order payment of a claim even though the Claims Administrator has not abused its discretion in denying the claim. In such a case the hearing examiner will apply an "abuse of discretion" standard in making his proposal for decision and will advise the Board of Trustees in his proposal that the Board has the right to order the claim paid even though no abuse of discretion has been found.

BT. **Office Visit** is a visit performed by a physician for a covered service in which the reimbursement of the charge is not included in any other procedure already considered for benefits.

BU. **Other Medical Expense** means the Allowable Amount incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

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

A service or supply is furnished at the direction of a Physician or Other Provider if the listed service or supply is:

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

An expense shall have been incurred on the date of provision of the service for which the charge is made. Other Medical Expense shall include:

1. Services of Physicians or Other Providers.
2. Services of a certified registered nurse-anesthetist.
3. Services of a licensed professional physical or occupational therapist.
4. Recognized services of a Christian Science Practitioner or other such spiritual care provider, when in lieu of Physician or Other Provider services, for Participants who rely solely on spiritual means through prayer in accordance with the teachings of a well-recognized church or denomination.
5. Diagnostic x-ray and laboratory procedures.
6. Radiation therapy.
7. Rental of Durable Medical Equipment required for therapeutic use unless purchase of such equipment is required by the Claims Administrator. In some cases the rental reimbursement of such equipment may exceed the purchase price of the equipment. No requirement by the Claims Administrator to purchase Durable Medical Equipment shall preclude the Claims

Article I Definitions (Continued)

Administrator from denying benefits for future rental of Durable Medical Equipment, when appropriate.

8. Ambulance Service.
9. Anesthetics and administration thereof when performed by someone other than the operating Physician or Other Provider.
10. Oxygen and its administration, provided the oxygen is actually used.
11. Blood, including cost of blood, blood plasma and blood plasma expanders, which is not replaced by or for the Participant.
12. Prosthetic Appliances such as:
 - (a) prostheses (including training prostheses) required for the alleviation or correction of conditions, including Accidental Injuries commencing after the Participant's Effective Date of coverage under a the Texas Employees Group Benefits Program self insured Plan or
 - (b) appliances prescribed as a result of a mastectomy.

Benefits for Prosthetic Appliances shall be limited to a maximum of \$10,000.00 for a single occurrence.

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

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

14. Services of a Physician or Other Provider to restore loss of or correct an impaired speech or hearing function, subject to the provisions of Section E, Subsection 8, of Article IV.
15. Home Infusion Therapy when the treatment is provided by a Home Infusion Therapy Provider and the treatment plan is preauthorized by the Home Infusion Therapy Provider in accordance with the Plan's established procedures. Treatment provided by an entity that does not contract with the Claims Administrator or is not accessible through BlueCard Worldwide as a provider of Home Infusion Therapy will not be covered as an Other Medical Expense. Any item of Home Infusion Therapy covered under this Subsection 15 will not be eligible for benefits under any other provision of the Plan.
16. Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center or other Facility, or a Substance Abuse Facility.

Article I Definitions (Continued)

17. Outpatient allergy testing.
 18. Inoculations against communicable diseases.
 19. Surgical implants prescribed by a Physician or Other Provider as a result of a mastectomy.
 20. Over-the-counter enteral formula when prescribed by a Provider and is life-sustaining as the sole source of nutrition and is determined by the Claims Administrator to be Medically Necessary.
- BV. **Out-of-Pocket Coinsurance Maximum** means the coinsurance amount that a Participant must pay in a Calendar Year (excluding Copayments) before HealthSelect pays 100% of remaining covered expenses (up to the Allowable Amount).
- BW. **Outpatient** means a Participant who has been admitted to a Hospital or Facility for less than 24 consecutive hours.
- BX. **Outpatient Care** means care provided to an Outpatient.
- BY. **Outpatient Day-Surgery Copayment** means the dollar amount a Participant must pay for outpatient day-surgery. This copayment will only apply when an operating room or treatment room is billed.
- BZ. **Outpatient Hospital Expense** means charges incurred for Medically Necessary items of service or supply for the care of a Participant, provided that such items are:
- (1) Furnished at the direction or prescription of a Physician or Other Provider;
 - (2) Provided by a Hospital; and
 - (3) Furnished to and used by the Participant during an outpatient visit; and provided further that for facilities other than contracting Hospitals, such charges are reasonable. An expense shall be deemed to have been incurred on the date of provision of the service for which the charge is made.
- CA. **ParPlan Provider** means a Physician or Other Provider who has signed an agreement with BCBSTX agreeing to the following:
- (1) Accept the BCBSTX Allowable Amount,
 - (2) File claims for patients covered by BCBSTX; and
 - (3) Not bill the Participant for services or supplies determined to be not Medically Necessary as determined by BCBSTX.
- CB. **Participant** means an Employee, Retiree, or a Dependent, as defined in the Act, and surviving Dependents of deceased Employees and Retirees who are eligible for coverage under the Plan in accordance with the Employees Retirement System of Texas Rules, which are incorporated herein by reference, and whose coverage under the Plan has become effective in accordance with the Employees Retirement System of Texas Rules.
- CC. **Part-Time Employee** means an Employee as defined by Section 1551.003(11) in the Act.

Article I Definitions (Continued)

- CD. **Physician** means a person, when acting within the scope of his license (other than a Hospital resident or intern), who is a Doctor of Medicine or Doctor of Osteopathy.
- CE. **Plan Administrator** means the Employees Retirement System of Texas.
- CF. **Plan Anniversary** means the month, day, and year of the Plan Effective Date and the corresponding date in each year thereafter for so long as the Plan is in force.
- CG. **Plan Effective Date** means the date on which coverage for the HealthSelect of Texas Comprehensive Medical Care Plan (Out-of-Area Benefits) begins, as specified on the face page hereof.
- CH. **Plan Month** means each succeeding monthly period, beginning on the Plan Effective Date.
- CI. **Plan Service Area** means the geographical area or areas designated by the Trustee which determines eligibility for BlueChoice® Network benefits.
- CJ. **Plan Year** means the period beginning on September 1 and ending on the next succeeding August 31, inclusive.
- CK. **Preadmission Testing Services** means tests performed on an outpatient basis and billed for by a Hospital (or shown by the Participant to otherwise be Preadmission Testing Services) which:
1. Are performed after a Hospital Admission has been scheduled or ordered;
 2. Are performed in lieu of tests following a Hospital Admission; and
 3. Are required by the rules and regulations of the Hospital's medical staff before Hospital bed patient treatment of the condition diagnosed can commence provided that:
 - (a) The Participant is subsequently admitted to a Hospital for the original diagnosed condition or other condition diagnosed from the testing;
 - (b) The tests are acceptable to the admitting Hospital; and
 - (c) The tests are not duplicated prior to or after admission unless such duplicated tests are justified on the basis of Medical Necessity.
- CL. **Preauthorization** means a process by which the Claims Administrator establishes in advance the Medical Necessity of certain care and services covered under the HealthSelect Plan. Preauthorization ensures that preauthorized care and services will not be denied on the basis of Medical Necessity. It is required for:
1. Hospital Admissions
 2. Skilled Nursing in a Skilled Nursing Facility
 3. Private-Duty Nursing
 4. Home Health Care
 5. Psychiatric Intermediate Care Facilities

Article I Definitions (Continued)

6. Hospice Care

7. Home infusion Therapy

CM. **Predetermination** means a process by which the Claims Administrator will review a proposed medical procedure to determine if benefits may be available under HealthSelect. A request for Predetermination must be submitted in writing to the BCBSTX Customer Service Department. This request should provide enough medical information from the Participant's Provider to determine the availability of benefits.

The Claims Administrator may request such information as:

- (1) Procedure code of the service to be rendered,
- (2) Medical documentation with supporting records, and
- (3) Diagnosis of the patient relevant to the procedure.

A Predetermination confirms the Medical Necessity of the care the Participant may receive. It does not guarantee payment. Payment will be determined after the claim is filed and is subject to eligibility, Allowable Amount, and other HealthSelect provisions, limitations and exclusions in effect at the time services are rendered.

CN. **Private-Duty Nurse** means a registered or licensed vocational nurse who is not related to the Participant by blood or marriage and is privately employed rather than employed through a Hospital.

CO. **Private-Duty Nursing** means services of a Private-Duty Nurse in a patient's home that are not part of a Hospice or Home Health Care visit.

CP. **Program** means the Texas Employees Group Benefits Program as established by the Board of Trustees.

CQ. **Proof of Loss** means written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim, and correct diagnosis code(s) and procedure code(s) for the services and items; and
3. Any other information reasonably necessary to process the claim or to determine liability, if any, under the Plan including, but not limited to, medical records from a Provider(s), and provided at no expense to the Plan.

When the Claims Administrator requests information to process the claim or determine its liability, if any, under the Plan, Proof of Loss is not complete until such information is received in writing at the specified office of the Claims Administrator.

CR. **Prosthetic Appliances** means artificial devices which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances, wigs, and the replacement of cataract lenses).

Article I Definitions (Continued)

- CS. **Prosthetics Provider** means a certified Prosthetist that supplies both standard and customized prostheses.
- CT. **Provider** means a Facility, Hospital, Physician (as defined in Article I of this Plan) or Other Provider that is licensed to provide services and supplies within the scope of their license. Other Providers shall include only the following, unless otherwise provided herein:
1. Doctor of Chiropractic
 2. Doctor of Dentistry
 3. Doctor of Optometry
 4. Doctor of Podiatry
 5. Doctor in Psychology (certified as a health service provider)
 6. Licensed Audiologist
 7. Licensed Dietitian
 8. Licensed Hearing Aid Fitter and Dispenser
 9. Licensed Marriage and Family Therapist
 10. Licensed Master Social Worker-Advanced Clinical Practitioner
 11. Licensed Professional Counselor
 12. Licensed Speech-Language Pathologist
 13. Spiritual Care Provider (for example, Christian Science Practitioner)
 14. Therapeutic Optometrist
 15. Licensed Chemical Dependency Counselor
 16. Licensed Psychological Associate
 17. Physicians' Assistant (must be approved by the Claims Administrator)
 18. Advanced Practice Nurse (must be approved by the Claims Administrator)
 19. Nurse First Assistant
 20. Licensed Surgical Assistant (effective January 1, 2003)

In states where there is a licensure requirement, Other Providers must be licensed by the appropriate state administrative agency. Other Providers must also meet state licensing requirements comparable

Article I Definitions (Continued)

to those applicable in the state of Texas in order to receive benefits under the Plan, regardless of whether services are provided in the state of Texas.

Benefits are only available for services provided by providers included in this definition or as referenced in the definition of Other Medical Expense.

- CU. Psychiatric Day Treatment Facility** means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Health Care Organizations and is approved by the Claims Administrator as a Psychiatric Day Treatment Facility for the provision of Behavioral Health Care and Serious Mental Illness services to Participants for periods of time not to exceed eight hours in any 24-hour period. Any treatment in a Psychiatric Day Treatment Facility must be certified in writing by the attending Physician to be in lieu of hospitalization.
- CV. Psychiatric Intermediate Care Facility** means a Crisis Stabilization Unit or Facility, Psychiatric Day Treatment Facility, Residential Treatment Center for Children and Adolescents, or other licensed facility or unit which is approved by the Claims Administrator as a Psychiatric Intermediate Care Facility. A Psychiatric Day Treatment Facility shall provide treatment of not more than eight hours in a 24-hour period.
- CW. Renal Dialysis Center** means a facility which is Medicare certified as an end-stage renal disease Facility providing staff assisted dialysis and training for home and self-dialysis.
- CX. Residential Treatment Center for Children and Adolescents** means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Health Care Organizations or the American Association of Psychiatric Services for Children and is approved by the Claims Administrator as a residential treatment center for the provision of certain categories of Behavioral Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.
- CY. Retiree** means an Employee who has retired as defined in the Act, and, for purposes of this Comprehensive Medical Care Plan (Out-of-Area Benefits), is:
- (1) Under the age of 65 and living outside the Plan Service Area, or
 - (2) Is age 65 or older.
- CZ. Routine Eye Exam** means an eye examination by a Doctor of Ophthalmology or a Doctor of Optometry which, when within the scope of their license, includes such services as:
- (1) External examination of the eye and its structure,
 - (2) Determination of refractive status, and
 - (3) Glaucoma screening test.
- A Routine Eye Exam does not include a contact lens exam.
- DA. Routine Foot Care** means hygienic and preventive maintenance care of the foot, including the cutting or removal of corns or callouses, nail trimming (including mycotic nails), and self-care, such as soaking of the feet. Routine Foot Care also includes any services performed in the absence of localized illness, injury, or symptoms involving the feet, and any treatment of a fungal (mycotic) infection in the absence of:

Article I Definitions (Continued)

- (1) Clinical evidence of mycosis of the toenail,
 - (2) Compelling medical evidence documenting that the patient either:
 - (i) Has a marked limitation of ambulation requiring active treatment of the foot; or
 - (ii) In the case of a nonambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment; and excision of a nail without using an injectable or general anesthetic.
- DB. **Rule** or **Rules** means those rules adopted by the Board of Trustees of the Employees Retirement System of Texas pursuant to the Act.
- DC. **Rural Health Clinic** means a medical clinic, whether urban or rural, serving underserved areas lacking sufficient health professionals. Primary ambulatory care and services may be provided by a Physician or by a properly licensed or certified practitioner under a Physician's supervision. The clinic must comply with all applicable federal, state, and local requirements and be approved by and contracted with BCBSTX or be accessible through BlueCard Worldwide as a Rural Health Clinic.
- DD. **Schedule** means the Schedule of Specifications attached hereto and made a part of the Plan, or the latest of any revised Schedules mutually agreed to by the Board of Trustees of the Employees Retirement System of Texas and the Claims Administrator to replace one previously in effect. If more than one Schedule of Specifications is in effect under the Plan, the term shall mean, for each Employee covered and for each Participant under his coverage, the Schedule of Specifications which has Eligibility Requirements that are applicable to such Employee.
- DE. **Serious Mental Illness** means the following psychiatric illnesses as defined by the American Psychiatric Association in the *Diagnostic and Statistical Manual (DSM) IV*:
1. Schizophrenia;
 2. Paranoid and other psychotic disorders;
 3. Bipolar disorders (mixed, manic and depressive);
 4. Major depressive disorders (single episode or recurrent);
 5. Schizo-affective disorders (bipolar or depressive);
 6. Pervasive developmental disorders;
 7. Obsessive-compulsive disorders; and
 8. Depression in childhood and adolescence.
- DF. **Skilled Nursing Facility** means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which:
1. Is licensed in accordance with state law (where the state law provides for licensing of such facility); and

Article I Definitions (Continued)

2. Is Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.
- DG. **State Agency** means a commission, board, agency, division, institution of higher education, or other agency of the state of Texas created by the constitution or statutes of this state. This term also includes the Texas Municipal Retirement System and the Texas County and District Retirement System.
- DH. **Subscriber Identification Number (Subscriber ID)** means the Subscriber ID Number shown on the HealthSelect ID card which identifies the subscriber. It is usually the Employee's or Retiree's social security number preceded by the letters ZGB.
- DI. **Substance Abuse (Chemical Dependency)** means the abuse of or psychological dependence on or addiction to alcohol or a controlled substance as defined in Article 3.51-9 of the *Texas Insurance Code*.
- DJ. **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 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 abuse dependency treatment program or center by any State 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 abuse 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.
- DK. **Telemedicine Services** are health care services provided by use of interactive audio, video, or other electronic media to deliver health care. This term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. This term does not include services performed using a telephone, facsimile machine, or Internet.
- DL. **Therapeutic Center** means an institution which is appropriately licensed, certified, or approved by the state in which it is located and which is:
1. An Ambulatory Day Surgery Facility;
 2. A freestanding radiation therapy center; or
 3. A freestanding birthing center.
- DM. **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

Article I Definitions (Continued)

occupation in which the Employee earns substantially the same compensation earned prior to disability; and

2. As applied to a Retiree, the complete inability of the Retiree to carry on all of the normal duties or activities of a person in good health who is the same sex and approximate age; and
3. As applied to a Dependent, confinement as a bed patient in a Hospital.

DN. **Trustee** means the Board of Trustees of the Employees Retirement System of Texas.

Article II Eligibility for Coverage; Effective Dates

Any Employee or Retiree and/or his eligible Dependents who are not eligible for or elect not to be covered under the Managed Care Plan (In-Area Benefits) of the HealthSelect Plan shall be eligible to apply for coverage under this Comprehensive Medical Care plan (Out-of-Area Benefits). The following eligibility and Effective Date provisions shall apply. Except as may be described in Section F, below, wherever the term “Retiree” is used, it shall mean the definition described in Article I, Section CY.

A. Eligibility for Coverage

1. Any Employee or Retiree shall, upon the date he becomes an Employee or Retiree, become eligible to apply for coverage under the Plan for himself or for himself and his family members as Dependents in accordance with “the Rules” established by the Employees Retirement System of Texas, incorporated herein by reference. A Dependent who is covered as an Employee or Retiree is not eligible for coverage as a Dependent. A Dependent may not be covered by more than one Employee or Retiree.
2. Eligible Dependents acquired after the Effective Date of the Employee’s or Retiree’s coverage shall become eligible in accordance with the Rules.
3. Coverage of the Employee or Retiree shall be a condition precedent to coverage of his Eligible Dependents and no Dependent shall be covered under the Plan prior to the Employee’s or Retiree’s Effective Date.

B. Application for Coverage

Coverage of each eligible Employee or Retiree and his eligible Dependents shall be contingent upon the Employee or Retiree making application in accordance with the Rules; thereupon, subject to acceptance by the Plan, when Evidence of Insurability is required, coverage shall become effective in accordance with the Rules.

C. Effective Dates – Timely Applications

If the application is for the initial coverage of an Employee or Retiree and his eligible Dependents and if the application is received by the Employing Office Benefits Coordinator or Employees Retirement System of Texas within the first 30 days following the Employee’s or Retiree’s date of eligibility, the coverage will become effective in accordance with the Rules. If the application is received on or before the first day of eligibility, coverage will become effective on the first day of eligibility.

D. Effective Dates – Late Applications

If an application for coverage for those eligible in accordance with Article II, Section A, is received by the Employing Office or the Employees Retirement System of Texas more than 30 days after the date such Employee or Retiree or Dependent becomes eligible, no coverage shall become effective unless the Plan provides written notice of approval. A condition for such approval of coverage for any person included in such application shall be the submission by the Employee or Retiree, without expense to the Plan, of Evidence of Insurability satisfactory to the Plan for each person included in the application. If the Plan determines the required evidence to be satisfactory and agrees in writing to approve the application, the coverage for each person approved shall become effective on the first day of the Plan Month following the date the Employing Office or the Employees Retirement System of Texas receives approval of the application.

**Article II Eligibility for Coverage;
Effective Dates (Continued)**

E. Plan Service Area

1. If an Employee or Retiree under the age of 65 does not reside in the Plan Service Area and the Employee's place of employment is not within the Plan Service Area, and he is enrolled in the Comprehensive Medical Care Plan (Out-of-Area Benefits), benefits will be available as specified in Article IV of this Master Benefit Plan Document.
2. If an Employee or Retiree under the age of 65 living or working within the Plan Service Area has covered Dependents living outside the designated Plan Service Area, the Employee or Retiree may choose coverage under the Managed Care Plan (In-Area Benefits) or this Comprehensive Medical Care Plan (Out-of-Area Benefits) for the Dependent.
3. If the Participant is an eligible Retiree under age 65 and not Medicare eligible, the type of coverage he has usually depends on whether he lives in the Plan Service Area. Employees under age 65 who live Out-of-Area but select In-Area as an Active Employee based on their work county, will be allowed to continue to have In-Area coverage upon retirement. This coverage will remain in effect until the Retiree turns age 65, notifies ERS that he wishes to change the election to Out-of-Area coverage following a residential move, or elects Out-of-Area coverage during the annual summer enrollment period. Once this change is made, the Retiree will not be allowed to change the election again unless his residential county changes to an In-Area location.
4. All address changes must be made in writing by an Employee or Retiree under age 65. The Employee must notify his Employing Office benefits coordinator and the Retiree under age 65 should notify the Employees Retirement System of Texas. An address change may result in benefit changes if the Employee or Retiree under age 65 moves out of the Plan Service Area. If an Employee or Retiree under age 65 moves his residence outside the Plan Service Area, his coverage will be changed to this Comprehensive Medical Care Plan (Out-of-Area Benefits). If the Employee or Retiree under age 65 moves into the Plan Service Area from a location outside the Network, his coverage will be changed to the Managed Care Plan (In-Area Benefits).

F. Employees Over Age 65 and Retirees

1. If the Employee attains age 65 and continues to be Actively at Work, HealthSelect coverage will continue under the Comprehensive Medical Care Plan (Out-of-Area Benefits). The HealthSelect coverage will be the Primary Plan for payment of benefits and Medicare will be the Secondary Plan.
2. If the Employee retires prior to attaining age 65 and is not eligible for Medicare, he may continue HealthSelect coverage, either under the Managed Care Plan (In-Area Benefits) or the Comprehensive Medical Care Plan (Out-of-Area Benefits), as applicable.
3. If the Employee retires prior to attaining age 65 and is Medicare eligible due to a disability, Medicare will be the Primary Plan for payment of benefits and HealthSelect coverage will be the Secondary Plan.

**Article II Eligibility for Coverage;
Effective Dates (Continued)**

4. If the Employee retires after attaining age 65, coverage may be continued under HealthSelect, but only under the Comprehensive Medical Care Plan (Out-of-Area Benefits); and
 - a. If the date of retirement is prior to September 1, 1992, and
 - (1) The Retiree has enrolled for both Parts A and B of Medicare, Medicare will be the Primary Plan for payment of benefits and the Comprehensive Medical Care Plan (Out-of-Area Benefits) will be the Secondary Plan; or
 - (2) The Retiree has enrolled for only Part A of Medicare, Medicare will be the Primary Plan for payment of benefits for Facility charges. The Comprehensive Medical Care Plan (Out-of-Area Benefits) will be the Secondary Plan for Facility charges and the only plan for medical-surgical services; or
 - (3) The Retiree has enrolled for only Part B of Medicare, Medicare will be the Primary Plan for payment of benefits for medical-surgical services. The Comprehensive Medical Care Plan (Out-of-Area Benefits) will be the only plan for Facility charges and the Secondary Plan for medical-surgical services; and
 - b. If the date of retirement is on or after September 1, 1992, the same coordination of benefits provisions will apply as specified above, except that if the Retiree has enrolled for only Part A of Medicare, Medicare will be the Primary Plan for payment of benefits for facility charges and the Comprehensive Medical Care Plan (Out-of-Area Benefits) will be the Secondary Plan for all charges.
5. If the Participant is an Active Employee and does not have Medicare, but the Participant's spouse has Medicare, HealthSelect will be the Primary Plan and Medicare will be the Secondary Plan for the Spouse.
6. If the Participant is an Active Employee or Retiree under age 65 who is determined to be disabled by Social Security and Medicare is the Primary Plan, the Participant and all covered Dependents have Out-of-Area coverage.

If the Participant has Medicare secondary coverage and a covered Dependent has Medicare primary coverage due to age, the Dependent has Out-of-Area coverage regardless of where the Participant resides.

If a covered Dependent has Medicare primary coverage due to disability, that Dependent has Out-of-Area coverage secondary to Medicare.

**Article III Payment of Benefits; Participant/Provider Relationship;
Coordination of Benefits**

A. Payment of Benefits

1. Payment of benefits to the Provider furnishing the service or to the Employee or Retiree, as the Claims Administrator may elect, shall constitute full discharge of all responsibility to the Employee or Retiree on account of benefits available to any Participant under the Plan.
2. Notwithstanding Subsection 1, above, of this Section A:
 - a. If payment in full or part has not been made to either the Provider furnishing the service or to the Employee or Retiree for services or supplies provided to a minor child who is a Dependent of the Employee or Retiree, benefits may be paid on behalf of such child to a person other than the Provider, Employee, or Retiree if an order by a court of competent jurisdiction names such person the managing conservator of such child and such person has paid for the services or supplies provided to the child; and
 - b. To be eligible to receive benefits, a managing conservator of a child must submit to the Claims Administrator, with the claim form, proof of payment of charges for such services or supplies, written notice that such person is the managing conservator of the child on whose behalf the claim is made, and a certified copy of a court order establishing the person as managing conservator.
3. The rights and benefits of the Plan shall not be assignable, either before or after services and supplies are provided, except for direct payment that the participant may assign to providers of health care services.
4. It is understood and agreed that the allowances set out in Article IV for services and supplies furnished by a Provider are not intended to and do not fix the value of the services of the Provider nor in any way relate to or regulate such value; that such Supplier is privileged to make its regular charges and that the stipulated amounts are merely to apply as credits thereon.
5. Any benefits payable to the Employee or Retiree shall, if unpaid at his death, be paid on the establishment of a valid claim to the person or persons surviving at the date of his death, in the following order of precedence:

First, to the beneficiary or beneficiaries designated by the Employee or Retiree in a signed and witnessed writing received before death in the Employing Office. For this purpose, a designation, change, or cancellation of beneficiary in a will or other document not so executed and filed has no force or effect.

Second, if there is no designated beneficiary, to the widow or widower of the Employee or Retiree.

Third, if none of the above, to the child or children of the Employee or Retiree and descendants of deceased children by representation.

Fourth, if none of the above, to the parents of the Employee or Retiree or the survivor of them.

Fifth, if none of the above, to the duly appointed executor or administrator of the estate of the Employee or Retiree.

**Article III Payment of Benefits; Participant/Provider Relationship;
Coordination of Benefits (Continued)**

Sixth, if none of the above, to other kin of the Employee or Retiree entitled under the laws of the domicile of the Employee or Retiree at the date of his death.

If, within one year after the death of the Employee or Retiree, no claim for payment has been filed by a person entitled under the order of precedence named above, or if payment to the person within that period is prohibited by any statute or regulation, payment may be made in the order of precedence as if the person had predeceased the Employee or Retiree; and the payment bars recovery by any other person.

If, within two years after the death of the Employee or Retiree, no claim for payment has been filed by a person entitled under the order of precedence named above and neither the Trustee nor the Claims Administrator has received notice that such a claim will be made, payment may be made to the claimant who, in the judgment of the Trustee, is equitably entitled thereto, and the payment bars recovery by any other person.

If, within four years after the death of the Employee or Retiree, payment has not been made under this Section A and no claim for payment by a person entitled under this Section A is pending, the amount payable escheats to the credit of the Fund as defined in the Act.

B. Participant/Provider Relationship

The choice of a Provider is made solely by a Participant. The Plan does not furnish services or supplies but only makes payment for Covered Services and Supplies incurred by Participants. Neither the Plan nor the Claims Administrator is liable for any act or omission by any Provider, and they do not have any responsibility for a Provider's failure or refusal to provide services or supplies to a Participant.

C. Coordination of Benefits

It is hereby declared to be the intent of the Plan that the availability of benefits specified in the Plan shall be subject to coordination of benefits as described below:

1. Definitions, as used in this Section C:
 - a. "Health Plan" means any group or group-type arrangement of coverage whether insured or uninsured which provides health benefits or services to a Participant either by indemnity or prepaid services by means of:
 - (1) Group or blanket insurance;
 - (2) Franchise insurance that terminates upon cessation of employment;
 - (3) Group hospital or medical service plans and other group prepayment coverage;
 - (4) Health maintenance organization coverage; or
 - (5) Any coverage under labor-management trustee arrangements, union welfare arrangements, employer organization arrangements, government benefit arrangements, or government programs.

**Article III Payment of Benefits; Participant/Provider Relationship;
Coordination of Benefits (Continued)**

Group-type contracts are contracts which are not available to the general public and can be obtained and maintained only because of membership in or connection with a particular organization or group. Group-type contracts are included in this definition, whether or not uninsured arrangements or individual (franchise) contract forms are used and regardless of how the group-type coverage is designated.

“Health Plan” does not include:

- (1) Any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy; or
- (2) A policy of health insurance that is individually underwritten and individually issued.

b. “This Health Plan” means the group health care program provided by the Plan.

c. “Expense” means any item of expense for health care when the item of expense is covered at least in part by one or more Health Plans covering the Participant for whom the claim is made; provided, however, that in no event shall the provisions of this item c be construed to increase the amount of total benefits which would be available under This Health Plan in the absence of another Health Plan.

d. “Primary Plan/Secondary Plan” means:

- (1) A Primary Plan is a Health Plan whose benefits for a Participant’s health care coverage must be determined without consideration of the existence of any other health plan.
- (2) A Secondary Plan is one which is not a Primary Plan. If a Participant is covered by more than one Secondary Plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

2. When a Participant is covered under This Health Plan and by one or more other Health Plans, the benefits of This Health Plan shall be coordinated and determined in accordance with the provisions of this Section C. When another Health Plan is a Primary Plan under the order of benefit determination rules contained herein but such Health Plan contains “excess” or “always secondary” provisions, the Health Plan which has been in force for the longest period of time will be the Primary Plan.

3. This Health Plan determines its order of benefits using the first of the following rules which applies:

a. The benefits of a Health Plan which covers the Participant on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a Health Plan which covers the Participant as a Dependent.

b. The benefits of a Health Plan which covers the Participant on whose expenses claim is based as a Dependent of a person whose birthday occurs earlier in a Calendar Year shall be determined before the benefits of a Health Plan which covers such Participant as a Dependent of a person whose birthday occurs later in a Calendar

**Article III Payment of Benefits; Participant/Provider Relationship;
Coordination of Benefits (Continued)**

Year. However, if either Health Plan does not have the provisions of this Paragraph b which results either in each Health Plan determining its benefits before the other, or in each Health Plan determining its benefits after the other, the provisions of this Paragraph b shall not apply, and the rule set forth in the other Health Plan shall determine the order of benefits; except that in the case of a Participant for whom claim is made as a Dependent child:

- (1) When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Health Plan which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a Health Plan which covers the child as a Dependent of the parent without custody;
 - (2) When the parents are divorced and the parent with custody of the child has remarried, the benefits of a Health Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Health Plan which covers that child as a Dependent of the stepparent, and the benefits of a Health Plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a Health Plan which covers that child as a Dependent of the parent without custody,
 - (3) Notwithstanding Subparagraphs (1) and (2) of this Paragraph b, when the parents are divorced or separated and there is a court decree which would otherwise establish financial responsibility for the health care expenses of the child, the benefits of a Health Plan which covers the child as a Dependent of the person with such financial responsibility shall be determined before the benefits of any other Health Plan which covers the child as a Dependent child.
- c. When Paragraphs a and b do not establish an order of benefits determination, the benefits of a Health Plan which has covered the Participant on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Health Plan which has covered such Participant the shorter period of time, except that:
- (1) The benefits of a Health Plan covering the Participant on whose expenses claim is based as a laid-off Employee or Retiree or as a Dependent of such Participant shall be determined after the benefits of any other Health Plan covering such Participant as an Employee other than as a laid-off Employee or Retiree or a Dependent of such person; and
 - (2) If either Health Plan does not have a provision regarding laid-off Employees or Retirees and as a result, each Health Plan determines its benefits after the other, then the provisions of Subparagraph (1) of this Paragraph c do not apply.
4. In the event of separate dental benefit coverage, This Health Plan shall be considered the Secondary Plan for any services for which benefits are available under both This Health Plan and that dental benefit coverage.
 5. Determination of benefits under this Section C shall be made in relation to the services furnished to a Participant during any one Calendar Year.

**Article III Payment of Benefits; Participant/Provider Relationship;
Coordination of Benefits (Continued)**

6. When This Health Plan is the Secondary Plan, the benefits of the other Health Plan shall be deducted from the charges of all items of Expense for which any benefit is provided under This Health Plan or the other Health Plan, and This Health Plan will pay the remainder of the charges for such items of Expense, provided, however;
 - a. If the Provider of service has entered into an agreement with the Claims Administrator to accept a determined fee for services provided, the provisions of this Section C shall not be construed to provide a benefit that is greater than the determined fee for those Expenses under This Health Plan less the benefits under the other Health Plan; or,
 - b. If the Provider of service has not entered into an agreement with the Claims Administrator to accept a determined fee for services provided, the provisions of this Section C shall not be construed to provide a benefit that is greater than the total of those charges incurred for those Expenses under This Health Plan less the benefits under the other Health Plan.
7. This Health Plan assumes no obligation to discover the existence of another Health Plan or the benefits available under it if discovered, but only to give effect to the provisions of this Section C in accordance with information furnished it by an authoritative source. It shall, however, be entitled to obtain and/or to release such information as reasonably necessary to give effect to these provisions without the consent of or notice to any person; and any person claiming benefits under This Health Plan shall, as a condition precedent to his right of recovery, furnish to the Claims Administrator full information concerning the existence of other Health Plans, the benefits thereof, and any other information as may be necessary to implement this coordination of benefits provision.
8. This Health Plan shall be entitled at any time to recover benefits paid in excess of the obligation as determined under the provisions of this Section C, irrespective of or to whom such benefits were paid, from an issuer, insurer, or provider of the other Health Plan, a Hospital, Facility, Physician, or Other Provider, or any person or firm to or for whom such payment was made, or from any combination of such sources.
9. When benefits have been paid under another Health Plan, This Health Plan shall have the right, in its discretion, to pay over to the issuer or provider of such other Health Plan any portion of the benefits available under This Health Plan which the Claims Administrator may determine to be due in order to give effect to the intent of this Section C and corresponding coordination of benefits provisions in such other Health Plan. The amount so paid shall be deemed to be benefits provided under This Health Plan and to the extent thereof, This Health Plan shall be fully discharged from liability.
10. If This Health Plan is the Secondary Plan under this Section C, but is unable to determine the benefits of the other Health Plan for the charges involved, the Claims Administrator may estimate in good faith the benefits of the other Health Plan and provide the benefits of This Health Plan on the basis of that estimate. Payment under this Subsection 10 shall constitute full discharge of the liability of This Health Plan for the charges involved, subject only to adjustment in the event the Plan later determines the actual benefits of the other Health Plan prior to the expiration of the period set forth in Article IX, Section J, of This Health Plan.

**Article III Payment of Benefits; Participant/Provider Relationship;
Coordination of Benefits (Continued)**

11. If it is determined that this benefit plan is the primary carrier/payor and that Medicare is the secondary carrier/payor, this Plan will pay benefits to the extent that it would were there no secondary carrier/payor. Medicare may pay part or all of a Provider's charges not covered by this plan, and Medicare may pay certain deductibles or other amounts on behalf of the Participant; however, this Plan and Master Benefit Plan Document make no warranty or representation as to the specific benefit Medicare may provide, and this Plan is not liable for any amount above the amount it would otherwise be liable to pay as primary carrier/payor were the Participant not eligible for Medicare.

If it is determined that this benefit plan is the secondary carrier/payor and that Medicare is the primary carrier/payor, after Medicare has determined its payment responsibility, this Plan will pay benefits as secondary carrier/payor as provided in the Master Benefit Plan Document, as amended. Medicare may pay part or all of a Provider's charges not covered by this plan, and Medicare may pay certain deductibles or other amounts on behalf of the Participant; however, this Plan and Master Benefit Plan Document make no warranty or representation as to the specific benefit Medicare may provide, and this Plan is not liable for any amount above the amount it would otherwise be liable to pay as secondary carrier/payor were the Participant not eligible for Medicare.

Article IV Benefits Provided

Subject to the conditions expressed herein and to the Limitations and Exclusions in Article V, when any Participant, while covered under the Plan, shall incur Covered Services and Supplies during a Calendar Year, benefits shall be determined as follows:

A. Inpatient Hospital Expense Benefits

1. Benefit Determination

If Inpatient Hospital Expense is incurred during each Hospital Admission in excess of the Deductible and Inpatient Copayments specified in Section D, below, the Plan will provide benefits equal to the amount specified in Item 2 of the Schedule.

2. Inpatient Preauthorization and Length-of-Stay Assignment

Preauthorization is required for each Hospital Admission. Preauthorization is the process by which the Medical Necessity of the length of stay of the Hospital Admission is approved or denied. Preauthorization does not guarantee payment of a claim but does ensure that payment for the covered room and board charges for the preauthorized length of stay will not be denied on the basis of Medical Necessity.

The Participant is required to have the length of stay of his Hospital Admission preauthorized prior to the actual admission (except in the case of an emergency admission) in order for maximum benefits to be available and to ensure that the length of stay of the admission is Medically Necessary. The length of stay of an emergency Hospital Admission must be preauthorized within 48 hours following the admission or transfer to another facility, or as soon thereafter as reasonably possible.

At the time Preauthorization of the Medical Necessity of the length of stay of the Hospital Admission is requested, a length-of-stay for the Hospital Admission will be assigned if it is determined that the Hospital Admission is Medically Necessary.

If Preauthorization is not obtained prior to an Inpatient Hospital Admission, the preauthorization penalty Deductible will be applied and benefits for room and board charges for medically unnecessary days will be denied; however, benefits for all other eligible Inpatient Hospital Expense will be provided.

3. Preadmission Testing Services

If Preadmission Testing Services are performed prior to the Participant's Hospital Admission, and

- a. The charges for such services are subsequently included in the total Inpatient Hospital Expense for the admission;
- b. The services are accepted by the admitting Hospital in lieu of any services required by the admitting Hospital; and
- c. If the Hospital Admission has been preauthorized,

Article IV Benefits Provided (Continued)

the Plan will provide the amount specified in Item 2 of the Schedule of Inpatient Hospital Expense involved for the Preadmission Testing Services in excess of the Deductible and Inpatient Copayments.

All Inpatient Hospital Expense incurred will be subject to any benefit limitations or conditions described in Section E of this Article IV.

The excess of Inpatient Hospital Expense involved over the above determined benefits are Deductible and Inpatient Copayment, if applicable, is the Participant's Coinsurance amount, except as otherwise provided in Section L of this Article IV.

B. Other Medical Expense Benefits

If Other Medical Expense is incurred during a Calendar Year in excess of the Deductible and Copayment amounts specified in Section D, below, the Plan will provide benefits equal to the amount specified in Item 2 or the Schedule of such excess, subject to the following exceptions:

1. All Other Medical Expense incurred will be subject to any benefit limitations or conditions as described in Section E of this Article IV;
2. For children ages 0 through 6 years, the following ten immunizations are covered at 100%, except when performed during an office visit: diphtheria, haemophilus influenzae type B, hepatitis B, measles, mumps, pertussis (whooping cough), polio, rubella, tetanus, varicella (chicken pox), and rotovirus.

The excess of Other Medical Expense involved over the above determined benefits, Deductible, and Copayments, is the Participant's Coinsurance amount, except as otherwise provided in Section L of this Article IV.

C. Extended Care Services and Home Infusion Therapy Benefits

Extended Care Services under the Plan includes skilled nursing care in a Skilled Nursing Facility, Home Health Care, Hospice Care, and Private-Duty Nursing services. To receive Home Infusion Therapy benefits, care and services must be furnished by Providers or Facilities that have contracted with the Claims Administrator or accessible through BlueCard Worldwide to provide those particular services. The Participant, his Physician or Other Provider must arrange for Preauthorization of the Medically Necessary services to be provided by a Skilled Nursing Facility, a Home Health Agency, Hospice, Private-Duty Nursing or a Home Infusion Therapy Provider.

If notification has been given that benefits for the requested services are not available, benefits will be denied. If the denial is based on the lack of medical necessity of a proposed treatment, a review of this determination through an appeal to the Claims Administrator and/or by an Independent Review Organization is available upon request and in accordance with Article IX, Section B.

Any remaining unpaid Extended Care Services will not be applied to any Coinsurance amounts.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be considered as Extended Care Services but will be considered an Other Medical Expense. These drug charges will not be paid under the Prescription Drug Program Supplementary Plan described in Exhibit C of the Plan.

Article IV Benefits Provided (Continued)

D. Deductibles and Copayment Amounts

The benefits of the Plan will be available after satisfaction of the applicable Deductible and Copayment amounts specified in the Schedule.

1. Deductibles

The Calendar Year Deductible specified below will apply for each Participant and shall be the responsibility of the Participant to pay. A Deductible required under one Subsection of this Article IV cannot be used to satisfy in whole or in part a Deductible required under another Subsection. The Deductibles described in Subsections 1 and 2, below, shall not be considered Coinsurance amounts under the Out-of-Pocket Coinsurance Maximum or Copayments under the Inpatient Copayment Maximum. The Deductible, if applicable, shall consist of the first Other Medical Expense and/or Extended Care Services expense for which benefits would be provided under Sections B and C, above, in the absence of the Deductible.

If Covered Services and Supplies which have day/visit maximums (such as Behavioral Health Care, Skilled Nursing Facility care, Home Health Care, and routine physical examinations) are applied to a Deductible, the days/visits shall also accumulate toward the day/visit maximum.

- (a) Failure to preauthorize in accordance with the Claims Administrator's procedures will result in a preauthorization penalty Deductible in addition to the Calendar Year Deductible. Benefits will not be available for the room and board charges for medically unnecessary days.
- (b) The Deductible shall be the amount specified in Item 2(a) of the Schedule per Participant each Calendar Year provided, however, when three Participants under the Employee's or Retiree's coverage satisfy individual Deductibles during a Calendar Year, this Deductible shall be deemed satisfied for all other Participants under the Employee's or Retiree's coverage for the remainder of that Calendar Year.
- (c) If two or more Participants of the same family are injured in the same accident, only one Deductible will be applied to all Other Medical Expense and/or Extended Care Services expense resulting from such accident for the Calendar Year in which the accident occurred.

2. Copayment Amounts

Certain care and treatment received under the Plan will require that a Copayment amount be paid at the time services are received. The Schedule indicates the Copayment amounts required. The Copayment amounts in most instances will be the lesser of the dollar amount set out for the particular service or the Allowable Amount for the service provided.

The Inpatient Copayment Maximum amount specified in Item 17 of the Schedule includes Inpatient Copayments paid for both Level I and Level II under the Managed Care Plan (In-Area Benefits). Any Inpatient Copayment Amounts under this Comprehensive Medical Care Plan (Out-of-Area Benefits) will be applied to both the Level I and Level II Inpatient Copayment Maximum specified in item 17 of the Schedule for the Managed Care Plan (In-Area Benefits).

Article IV Benefits Provided (Continued)

If the Participant is discharged from a Hospital Admission and readmitted within 24 hours of the original discharge, the Participant will not be required to pay additional copayments if he has already paid the Inpatient Copayment amount specified in Item 1 (c) of the Schedule, with the original admission.

Inpatient Copayments applied for behavioral health and intermediate behavioral health care also apply toward the Inpatient Copayment Maximum. The Inpatient Copayment Maximum does **not** include any Copayments paid for Outpatient Day-Surgery or Deductible amounts.

The Outpatient Day-Surgery Copayment amount specified in Item 2 (c) of the Schedule is the amount a Participant must pay for outpatient day-surgery. This copayment will only apply when an operating room or treatment room is billed and does not apply to the Inpatient Copayment Maximum specified in Item 17 of the Schedule.

E. Other Benefit Provisions

1. Benefits for Complications of Pregnancy

Benefits for the treatment of Complications of Pregnancy are available to all Employees, Retirees, spouses of Employees, spouses of Retirees, Dependent children of Employees, and Dependent children of Retirees. Benefits available under this Subsection 1 shall be considered on the same terms and provisions as for treatment of any sickness as described in this Article IV.

2. Benefits for Maternity Care

Benefits for Maternity Care are available to all Employees, Retirees, spouses of Employees, spouses of Retirees, Dependent Children of Employees, and Dependent children of Retirees. Benefits available for Maternity Care under this Subsection 2 shall be considered on the same terms and provisions as for treatment of any sickness as described in this Article IV.

3. Benefits for Newborn Well-Baby Care

Hospital and medical expenses for routine well-baby nursery care of a natural newborn child or an eligible newborn grandchild incurred during the mother's Hospital Admission for the delivery shall be considered eligible Inpatient Hospital Expense and Other Medical Expense of the natural newborn child or eligible newborn grandchild, provided the mother, father, or grandparent is covered under the Plan on the date the mother delivers the natural newborn child or the eligible newborn grandchild.

If a newborn natural child or eligible newborn grandchild remains hospitalized after the mother is released from the Hospital, any Inpatient Hospital Expense or Other Medical Expense incurred by the newborn natural child or eligible newborn grandchild shall not be considered expenses for Covered Services and Supplies unless a separate preauthorization for such child is obtained, and the child is admitted to the Hospital in its own name for treatment by a Physician or Other Provider for an abnormal condition.

The newborn natural child or eligible newborn grandchild will not be required to pay Inpatient Copayments for the delivery unless the child remains hospitalized after the mother is released or if the mother is not a covered Participant.

Article IV Benefits Provided (Continued)

4. Benefits for Serious Mental illness

Benefits for Covered Services and Supplies for the Medically Necessary treatment of Serious Mental Illness shall be considered on the same terms and provisions as for treatment of any physical sickness generally as specified in the Schedule.

All Inpatient treatment of Serious Mental Illness must be preauthorized through INROADS. If preauthorization is not obtained:

- (a) The Claims Administrator will review the Medical Necessity of the Participant's treatment prior to making a final benefit determination;
- (b) The Participant may be responsible for an additional preauthorization penalty Deductible for a Hospital Admission; and
- (c) Benefits may be reduced or denied if it is determined that the treatment is not Medically Necessary.

5. Benefits for Behavioral Health Care

a. Inpatient Hospital Expense:

All inpatient Behavioral Health Care, must be preauthorized through INROADS. If Preauthorization is not obtained:

- (a) The Claims Administrator will review the Medical Necessity of the Participant's treatment prior to making a final benefit determination;
- (b) The Participant may be responsible for an additional preauthorization penalty Deductible for a Hospital Admission; and
- (c) Benefits may be reduced or denied if it is determined that the treatment is not Medically Necessary.

Benefits for Inpatient Hospital Expense for Behavioral Health Care shall be determined in accordance with the requirements of Section A, above, except that the number of days available shall be limited to the number of days specified in Item 6 (a) (1) of the Schedule for each Participant, not to exceed the benefit percentage specified in Item 6 (a) (3) of the Schedule.

Medically Necessary Behavioral Health Care in a Psychiatric Intermediate Care Facility shall be deemed to be Inpatient Hospital Expense. Each day of an Inpatient Hospital Admission for Behavioral Health Care reduces by two the number of days available for services provided by a Psychiatric Intermediate Care Facility. Each two days of services provided by a Psychiatric Intermediate Care Facility reduces by one the number of days available for an Inpatient Hospital Admission for Behavioral Health Care. Preauthorization is required for all care received in a Psychiatric Intermediate Care Facility. If Preauthorization is not obtained, the preauthorization penalty Deductible will be applied and the Claims Administrator will review the Medical Necessity of the admission prior to final benefit determination.

Article IV Benefits Provided (Continued)

b. Other Medical Expense:

Benefits for Other Medical Expense for Behavioral Health Care shall be payable in accordance with Section B, above, subject to the following exceptions:

- (1) Inpatient Physician visits to a Participant shall be limited to one visit each day, up to the maximum number of visits specified in Item 6 (c) (1) of the Schedule, not to exceed the benefit percentage specified in Item 6 (c) (1) of the Schedule .
- (2) Outpatient Physician visits including outpatient group psychotherapy visits by a Participant shall be limited to the maximum number of visits specified in Item 6 (c) 2) of the Schedule, not to exceed the eligible expense specified in Item 6 (c) (2) (b) of the Schedule. Benefits shall be determined at the amount specified in Item 6 (c) (2) of the Schedule.
- (3) Outpatient visits by a Participant to the outpatient department of a Hospital or Psychiatric Intermediate Care Facility shall be limited to the number of visits specified in Item 6 (c) (2) of the Schedule, not to exceed the benefit percentage and Copayments specified in Item 6 (b) of the Schedule.

c. Benefits provided under this Subsection 5 shall not be applicable to treatment of Serious Mental Illness.

6. Benefits for Treatment of Substance Abuse (Chemical Dependency)

Benefits for expenses for Covered Services and Supplies incurred for treatment of Substance Abuse (Chemical Dependency) shall be considered on the same terms and provisions as for treatment of any other physical illness generally as specified in the Schedule. All services and supplies must be provided by a Hospital, a Facility, Physician, or Other Provider in order for benefits to be available.

Inpatient treatment of Substance Abuse must be provided in a Substance Abuse Facility. Benefits for the medical management of acute life-threatening intoxication (detoxification) in a Hospital are available under the Plan.

All Inpatient treatment of Substance Abuse (Chemical Dependency) must be preauthorized through INROADS. If Preauthorization is not obtained:

- (a) The Claims Administrator will review the Medical Necessity of the Participant's treatment prior to making a final benefit determination;
- (b) The Participant may be responsible for an additional preauthorization penalty Deductible specified in Item 1 (b) of the Schedule; and
- (c) Benefits may be reduced or denied if it is determined that the treatment is not Medically Necessary.

Any limitations of benefits for Behavioral Health Care as specified in Subsection 5, above, shall not apply to treatment of Substance Abuse.

Article IV Benefits Provided (Continued)

7. Benefits for Mammography Screening

If a Participant incurs Other Medical Expense for a screening by low-dose mammography for the presence of occult breast cancer, benefits will be determined on the same basis as for other radiological examinations at the amount specified in Item 9 of the Schedule and the Deductible specified in Section D, above, will be applied.

8. Benefits for Hearing Aids

- a. If a Participant incurs Eligible Expenses to restore loss or correct an impaired hearing function (including related fitting and dispensing charges, the cost but not repair of the hearing aid device, ear molds, batteries, and warranties), benefits will be determined at the amount specified in Item 10 (a) of the Schedule of the Allowable Amount, not to exceed the maximum benefit specified in Item 10 (b) of the Schedule during any consecutive three-year period. This maximum benefit shall include any Network or Non-Network benefits received under the Managed Care Plan (In-Area Benefits).
- b. The cost of the hearing aid device replacement batteries shall be a specific exception to the maximum benefit and shall not be applied to the maximum amount specified in Item 10 (b) of the Schedule.

No Deductible as specified in Section D, above, will be applied to any benefits available under this Subsection 8.

9. Benefits for Diabetic Management Services

If a Participant incurs Diabetic Management Services, benefits will be allowed on the same terms and provisions as for treatment of any physical sickness generally, subject to the same Deductibles, Copayments, and Coinsurance amounts, limitations and exclusions, and other Plan provisions.

10. Benefits for Dental Care Services

- a. Dental Care Services, as defined in Article I herein, are not a covered benefit under HealthSelect except for those services and supplies provided to a newborn natural child or eligible newborn grandchild which are necessary for treatment or correction of a congenital defect.
- b. Benefits are available for Covered Oral Surgery, as defined in Article I herein.
- c. Benefits are available for Inpatient Hospital Expenses and Other Medical Expenses incurred for a medically necessary hospital or ambulatory (day) surgery facility admission for Dental Care Services or Covered Oral Surgery.

11. Benefits for Routine Physical Exams

Routine physical examinations will be limited to one per calendar year for adult males and children, two per Calendar Year for adult females (one well-woman and one routine physical examination).

Article IV Benefits Provided (Continued)

12. Benefits for Routine Eye Exams

One Routine Eye Exam per Participant per Calendar Year. A Routine Eye Exam may be conducted by an ophthalmologist or an optometrist, and includes:

- (i) External examination of the eye and its structure;
- (ii) Determination of refractive status; and
- (iii) Glaucoma screening test. It does not include a contact lens exam.

13. Benefits for Organ and Tissue Transplants

a. Covered services and supplies related to an organ or tissue transplants include, but are not limited to:

- (1) X-rays, laboratory, chemotherapy, radiation therapy, prescription drugs, and complications arising from such transplant.
- (2) Evaluation of organs and tissues including but not limited to the determination of tissue matches; removal of organs or tissues from deceased donors; and transportation and storage of donated organs or tissues.

b. Benefits for covered services and supplies provided to a Participant (donor and/or recipient) by a Hospital Physician, or Other Provider related to an organ or tissue transplant will be determined as follows:

- (1) Donated human organs or tissue are used;
- (2) The recipient is a Participant under the Plan (benefits are also available to the donor who is a Participant under the Texas Employees Group Benefits Program);
- (3) The transplant procedure was preauthorized;
- (4) The participant meets all the criteria established by BCBSTX in its written medical policy guidelines;
- (5) The Participant meets all of the protocols established by the Hospital in which the transplant is performed.

c. Transplant benefits are available and will be determined on the same basis as any other sickness when the transplant procedure is for the following organ(s) or tissues:

- (1) Kidney;
- (2) Cornea;
- (3) Liver;
- (4) Heart;
- (5) Heart-lung;
- (6) Lung;
- (7) Pancreatic-kidney;
- (8) Bone marrow; and

Article IV Benefits Provided (Continued)

(9) Other organ transplants that are determined to be non-Experimental and/or non-Investigational according to current medical policy guidelines. Artificial organs (e.g. heart) are not covered.

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

- (1) Transplant procedures (including transplantation of non-human organs) or the services performed in preparation for, or in conjunction with such procedure, which BCBSTX considers to be Experimental and/or Investigational in nature;
- (2) Living and/or travel expenses of the live donor or recipient;
- (3) Donor search and acceptability testing of potential living donors;
- (4) Expenses related to maintenance of life for purposes of organ or tissue donations;
- (5) Purchase of the organ or tissue;
- (6) Donor expenses where donor is not a participant under the Texas Employees Group Benefits Program.

14. Benefits for Prostate Screening and Cancer Detection Services

An annual physical examination for the detection of prostate cancer is provided for male Participants. In addition, an annual prostate-specific antigen (PSA) test will be provided for male participants who are:

- a. At least fifty (50) years of age and asymptomatic;
- b. At least forty (40) years of age with a family history of prostate cancer or another prostate cancer risk factor.

15. Benefits for Telemedicine Services

Participants are eligible for coverage of Telemedicine Services as defined in Article I herein. Benefits provided through Telemedicine will be allowed on the same terms and conditions as for the treatment of any physical sickness generally, subject to the same Deductibles, Copayment amounts, Coinsurance amounts, limitations and exclusions, and any other applicable Plan provisions.

16. Benefits for Childhood Immunizations

The following childhood immunizations for Participants from birth through six (6) years of age are covered at 100%, except when performed during an office visit:

- a. Diphtheria;
- b. Hemophilus influenza type B;
- c. Hepatitis B;
- d. Measles;
- e. Mumps;

Article IV Benefits Provided (Continued)

- f. Pertussis (whooping cough);
- g. Polio;
- h. Rubella;
- i. Tetanus;
- j. Varicella (chicken pox); and
- k. Rotovirus

17. Benefits for Ambulance Services

Ambulance services must be:

- 1. Prescribed by a physician;
- 2. Medically Necessary; and
- 3. Approved by the Claims Administrator.

Benefits are paid at the amount specified in Item 2 of the Schedule of the allowed amount up to the coinsurance maximum. After the coinsurance maximum is met, benefits are payable at 100% of allowed amount for eligible charges.

18. Benefits for Bone Mass Measurement Services

Benefits for bone mass measurement is provided for qualified individuals for the detection of low bone mass and to determine a Participant's risk of osteoporosis and fractures associated with osteoporosis. A qualified individual is:

- a. A postmenopausal woman who is not receiving estrogen replacement therapy;
- b. An individual with vertebral abnormalities, primary hyperparathyroidism or a history of bone fractures; or
- c. An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

19. Colorectal Cancer Screening

Medical rectal screening for the detection of colorectal cancer is covered for Participants fifty (50) years of age or older for expenses incurred in conducting medically recognized diagnostic examinations for the detection of colorectal cancer. Such services include, but are not limited to:

- (a) Fecal occult blood test performed annually;
- (b) Flexible sigmoidoscopy with hemoccult of the stool performed every five (5) years; and
- (c) Colonoscopy performed every ten (10) years.

Benefits are determined at the amounts specified in Item 2 of the Schedule in excess of the Deductible and Copayment amounts specified in Section D, above. Any remaining unpaid Other Medical Expenses in excess of the Deductible and Copayments, if applicable, will be applied to the Coinsurance amount as specified in Item 16 of the Schedule.

Article IV Benefits Provided (Continued)

20. Treatment of Acquired Brain Injury

Coverage for treatment of Acquired Brain Injury will be the same as for treatment of any physical sickness generally, subject to the same Deductible, Coinsurance amounts, limitations and exclusions, and other applicable Plan provisions. Cognitive rehabilitation therapy; cognitive communication therapy; neurocognitive therapy and rehabilitation; neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, and community reintegration services are covered for treatment of conditions that are a result of and related to an acquired brain injury.

Benefits are determined at the amounts specified in Item 2 of the Schedule in excess of the Deductible and Copayment amounts specified in Section D, above. Any remaining unpaid Other Medical Expenses in excess of the Deductible and Copayments, if applicable, will be applied to the Coinsurance amount as specified in Item 16 of the Schedule.

21. Infertility Services

Participants (male and female) are eligible for infertility services which may include, diagnostic laboratory and x-ray procedures, therapeutic injections and surgical treatment necessary for the diagnosis and treatment of involuntary infertility subject to the same Deductibles, Coinsurance amounts, limitations and exclusions, and any other applicable Plan provisions. Covered services do not include sterilization reversal, transsexual surgery, gender reassignment, artificial insemination and related services, intra-fallopian transfer, or in vitro fertilization. Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures.

F. **Skilled Nursing Facility Benefits**

When skilled nursing care in a Skilled Nursing Facility has been preauthorized as explained in Section C, above, the Plan will provide benefits as specified below. If Preauthorization of Skilled Nursing Facility services has not been obtained, no benefits will be available under the Plan.

The Plan will pay the Skilled Nursing Facility for the Covered Services and Supplies provided at the amount specified in Item 11 of the Schedule of the Allowable Amount provided, however, that benefits for care in a Skilled Nursing Facility will be limited to the days and amounts specified in Item 11 of the Schedule. In determining the length of stay, the day of admission, but not the day of discharge, shall be considered.

No Deductible or Copayments will be applicable to this Section F. Charges in excess of the benefits available under this Section F shall not be considered Coinsurance amounts under Section L of this Article IV, unless and only to the extent that the services for which charges are incurred are otherwise available under other provisions of the Plan.

Any maximums applicable to benefits provided under this Section F shall include any Network Benefits and/or Non-Network Benefits received under the Managed Care Plan (In-Area Benefits).

Article IV Benefits Provided (Continued)

Services and supplies for Skilled Nursing Facility shall include:

- a. All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
- b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility;
- c. Physical, occupational (when consisting of traditional physical therapy modalities) speech, and respiratory therapy services by licensed therapists.

Benefits will **not** be provided for Skilled Nursing Facility services for:

- a. Purchase or rental of Durable Medical Equipment or dialysis equipment;
- b. Services provided primarily for Custodial Care;
- c. Services that a Physician or Other Provider has not certified as being Medically Necessary;
- d. Transportation services;
- e. Services not contained in the approved Skilled Nursing Facility treatment plan.

G. Home Health Care Benefits

When Home Health Care services have been preauthorized as explained in Section C of this Article IV, the Plan will provide benefits as specified below. If Preauthorization of Home Health Care services has not been obtained, no benefits will be available under the Plan.

The Claims Administrator will pay the Home Health Agency for the Covered Services and Supplies provided by the Agency in accordance with the Home Health Care Plan; provided, however, that benefits for Home Health Care visits to a Participant's home will be payable at the amount specified in Item 12 of the Schedule of the Allowable Amount and will be limited to the maximum number of visits or maximum benefit, whichever occurs first. Each visit by an R.N. or L.V.N. will be considered as one home health care visit, four hours of home health aide service will be considered as one home health care visit, and if any visit extends beyond four hours, each four hours or portion of that period is considered as one home health care visit.

If a Participant receives two or more home care visits on the same day, each visit will be counted toward the maximum.

No Deductibles or Copayments will be applicable to this Section G. Charges in excess of the benefits available under this Section G shall not be considered Coinsurance amounts under Section L of this Article IV, unless and only to the extent that the services for which charges are incurred are otherwise available under other provisions of the Plan.

Any maximums applicable to benefits provided under this Section G shall include any Network benefits and/or Non-Network Benefits received under the Managed Care Plan (In-Area Benefits).

Article IV Benefits Provided (Continued)

Services and supplies for Home Health Care services shall include:

- a. Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (LV.N.);
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- c. Physical, occupational (when consisting of traditional physical therapy modalities), speech, and respiratory therapy services by licensed therapists;
- d. Supplies and equipment routinely provided by the Home Health Agency.

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

- a. Food or meals delivered to the home;
- b. Social case work or homemaker services;
- c. Purchase or rental of Durable Medical Equipment or dialysis equipment;
- d. Services provided primarily for Custodial Care, including but not limited to bathing, dressing, cooking, or grooming;
- e. Services provided by a person who ordinarily resides in the Participant's home;
- f. Services that a Physician or Other Provider has not certified as being Medically Necessary;
- g. Transportation services;
- h. Home Infusion Therapy;
- i. Services not contained in the approved Home Health Care Plan.

H. Hospice Care Benefits

When Hospice Care services have been preauthorized as explained in Section C of this Article IV, the Plan will provide benefits as specified below. If Preauthorization of Hospice Care services has not been obtained, no benefits will be available under the Plan.

The Claims Administrator will pay the Hospice for the Covered Services and Supplies provided at the amount specified in Item 13 of the Schedule of the Allowable Amount. The maximum amount of benefits available for all types of Hospice Care shall be limited to the amount specified in Item 13 (b) of the Schedule during the lifetime of the Participant, including any Network Benefits and/or Non-Network Benefits received under the Managed Care Plan (In-Area Benefits).

No Deductible or Copayments will be applicable to this Section H. Charges in excess of the benefits available under this Section H shall not be considered Coinsurance amounts under Section L of this Article IV, unless and only to the extent that the services for which charges are incurred are otherwise available under other provisions of the Plan.

Article IV Benefits Provided (Continued)

Services and supplies for Home Hospice Care shall include:

- (1) Part-time or intermittent nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
- (2) Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- (3) Physical, occupational (when consisting of traditional physical therapy modalities), speech, and respiratory therapy services by licensed therapists;
- (4) Counseling services routinely provided by the Hospice agency, including bereavement counseling.

Services and supplies for Facility Hospice Care shall include:

- (1) All usual nursing care by a registered nurse (R.N.) or by a licensed vocational nurse (L.V.N.);
- (2) Room and board and all routine services, supplies, and equipment provided by the Hospice Facility;
- (3) Physical, occupational (when consisting of traditional physical therapy modalities), speech, and respiratory therapy services by licensed therapists;
- (4) Counseling services by licensed social workers and pastoral counselors routinely provided by the Hospice facility.

Benefits will **not** be provided under Hospice Care for:

- a. Food or meals delivered to the home;
- b. Homemaker services;
- c. Purchase or rental of Durable Medical Equipment or dialysis equipment;
- d. Services provided by a person who ordinarily resides in the Participant's home;
- e. Services that a Physician or Other Provider has not preauthorized as being Medically Necessary;
- f. Transportation services;
- g. Services not contained in the approved Hospice Care Plan.

I. Private-Duty Nursing Services Benefits

When Private-Duty Nursing services have been preauthorized as explained in Section C of this Article IV, the Plan will provide benefits as specified below. If Preauthorization of Skilled Nursing Facility services has not been obtained, no benefits will be available under the Plan.

Article IV Benefits Provided (Continued)

Other Medical Expense, in excess of the Deductible, shall be payable at the amounts specified in Item 8 of the Schedule of the Allowable Amount and shall not exceed the benefit maximum specified in Item 8 of the Schedule during the lifetime of the Participant.

Any Other Medical Expense incurred for Private-Duty Nursing services for which benefits are not provided under this Section I shall not be considered Coinsurance amounts under Section L of this Article IV.

Any maximums applicable to benefits provided under this Section I shall include any Network Benefits and/or Non-Network Benefits received under the Managed Care Plan (In-Area Benefits).

Services and supplies for Private-Duty Nursing shall include:

Services of a private-duty registered nurse (RN.) or licensed vocational nurse (L.V.N.) provided:

- (1) The services are ones which can be performed for compensation only by a person holding an R.N. license, an L.V.N. license or other license requiring a higher level of medical skill and training; and
- (2) The level of skill of an R.N. or L.V.N. is Medically Necessary; and
- (3) Charges will be eligible for benefits only for that portion of time for which such level of skill is Medically Necessary.

Examples of Private-Duty Nursing services not covered are those simply for the convenience of the patient or patient's family or those consisting primarily of such acts as bathing, feeding, mobilizing, exercising, homemaking, giving medication, or acting as a companion or sitter.

J. Case Management

The Claims Administrator, at its sole discretion, may elect to provide alternative benefits which are not otherwise Covered Services and Supplies under the Plan. Such election shall be made strictly on the initiative of the Claims Administrator. The Claims Administrator's determination to provide benefits in one instance shall neither commit the Claims Administrator to provide the same or similar alternative benefits for the same Participant or any other Participant, nor cause the Claims Administrator to waive its right to strictly apply the express provisions of the Plan in the future.

The Claims Administrator, in its sole discretion, may elect to provide alternative benefits under this Section J only if the Participant and the Participant's Physician or Other Provider concur.

1. Alternative benefits will be provided only if all the following conditions are met:
 - a. A Case Management Plan is established, in conjunction with the Participant's Physician or Other Provider, submitted in writing to the Claims Administrator, and approved by the Claims Administrator. Any Case Management Plan established as provided in this Section J must specify the type and amount of care;
 - b. A Case Management Agreement is established in writing between the Claims Administrator and the Participant, setting forth the terms of a Case Management Plan as established under this Section J, a waiver of liability, and such other terms and conditions as may be required by the Claims Administrator,

Article IV Benefits Provided (Continued)

- c. The charges for the alternative benefits are billed for on forms acceptable to the Claims Administrator.
2. Any alternative benefits provided or considered or denied in accordance with this Section J shall not be subject to review as a contested case under the provisions of Texas Government Code Ann. 2001.01, *et.seq.* (Vernon, 1995), or pursuant to the Act or Rules.

K. **BlueCard Worldwide®**

A benefit available when traveling or living outside the United States.

1. By using participating hospitals when traveling or living outside the United States for inpatient hospital care, a Participant will avoid paying for the hospital stay and will only need to pay for out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance).
2. A Participant may choose to use a non-participating hospital; however, the hospital may have to be paid directly and a claim filed with the Claims Administrator for reimbursement of covered expenses.

L. **Coinsurance Stop-Loss (Out-of-Pocket Coinsurance Maximum); Maximum Lifetime Benefits**

1. Coinsurance Stop-Loss:

When the amounts subject to Coinsurance for a Calendar Year under this Article IV total the amount specified in Item 16 of the Schedule, the benefit percentages automatically become 100% for purposed of determining the benefits available for all other expenses incurred by such Participant during the Calendar Year involved, except that:

- a. The benefit percentage for Other Medical Expense for outpatient Physician or Other Provider visits for Behavioral Health Care shall not increase to 100%, but shall remain at the amount specified in Item 6(c) (2) of the Schedule.
- b. The benefit percentage for Other Medical Expense for Private-Duty Nursing services shall not increase to 100%, but shall remain at the amount specified in Item 8 of the Schedule.
- c. Any Coinsurance amounts under the Managed Care Plan (In-Area Benefits) will be applied to the Out-of-Pocket Coinsurance Maximum specified in Item 16 of the Schedule for this Comprehensive Medical Care Plan (Out-of-Area Benefits). Any Coinsurance amounts under this Comprehensive Medical Care Plan (Out-of-Area Benefits) will be applied to both the Level I and Level II Coinsurance Stop-Loss Amounts specified in item 16 of the Schedule for the Managed Care Plan (In-Area Benefits).

The terms Coinsurance and Out-of-Pocket Coinsurance Maximum shall not include:

- a. Any Inpatient Hospital Expense, Other Medical Expense and/or Extended Care Services when the Claims Administrator is the Secondary Plan under Article III, Section C, of the Plan;

Article IV Benefits Provided (Continued)

- b. Any remaining unpaid Inpatient Hospital Expense for Behavioral Health Care over and above the maximum number of days specified in Section E, Subsection 5, Paragraph (a), above;
- c. Any remaining unpaid Other Medical Expense or Extended Care Services for Behavioral Health Care over and above the maximum number of visits specified in Section E, Subsection 5, Paragraph b (2), above;
- d. Any Other Medical Expense for Private-Duty Nursing services which is not reimbursed under Section I, above;
- e. Any charges for Skilled Nursing Facility care, Home Health Care, and Hospice Care which are not reimbursed under this Article IV, unless and only to the extent that the services for which charges are incurred are otherwise available under other provisions of the Plan;
- f. Any remaining amounts of Other Medical Expense and/or Extended Care Expense after the Allowable Amount for such expenses is determined;
- g. Any other charges excluded or denied under the terms and conditions of the Plan.

2. Maximum Lifetime Benefits:

The amount of benefits available during the lifetime of any one Participant under the Plan shall be unlimited, except that:

- a. The maximum lifetime benefit amount specified in Item 8 (c) of the Schedule for Private-Duty Nursing; and
- b. The maximum lifetime benefit amount specified in Item 13 (b) of the Schedule for Hospice Care.

M. **Medical Necessity**

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by the Claims Administrator. Charges for services and supplies which the Claims Administrator determines are not Medically Necessary will not be eligible for the benefit consideration and may not be used to satisfy Deductibles or to apply to the Coinsurance stop-loss amount (Out-of-Pocket Coinsurance Maximum).

Article V Limitations and Exclusions

The benefits of the Plan are not available for:

- A. Any services or supplies which are not Medically Necessary for the diagnosis or treatment of an illness, injury, or bodily malfunction.
- B. Any services or supplies provided in connection with an occupational illness or an injury sustained in the scope of and in the course of employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- C. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of Behavioral Health Care or mental retardation provided by a tax supported institution of the state of Texas.
- D. Any services and supplies furnished by a Hospital or Facility that is not approved by BCBSTX (except in cases of Accidental Injury, the immediate, initial treatment necessary to stabilize the Participant furnished by any Hospital or Facility shall be subject to benefits as provided in the Plan) or any services or supplies furnished by a Hospital or Facility for which such institution has not been specifically approved to furnish by BCBSTX.
- E. Any services or supplies provided to any Participant for treatment of an injury or illness resulting from acts of war, declared or undeclared or while on active or reserve duty in the armed forces.
- F. Any charges: (1) resulting from the failure of the Participant to keep a scheduled visit with a Physician or Other Provider; (2) for completion of any insurance forms; or (3) for acquisition of medical records.
- G. A Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an Outpatient basis without adversely affecting the patient's physical condition or the quality of medical care provided; except that Inpatient Hospital Expense, other than room accommodation charges incurred during the Hospital Admission, shall be deemed to be Other Medical Expense and benefits for such expense shall be provided accordingly.
- H. Any items of Inpatient Hospital Expense or Other Medical Expense incurred for Dental Care Services, except as provided in Article IV, Section E, Subsection 10.
- I. Any services or supplies provided for the nonsurgical and/or nondiagnostic treatment of or related services to the temporomandibular (jaw) joint (TMJ) or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the TMJ and all adjacent or related muscles and nerves except that this exclusion shall not apply to any physical therapy which is necessary as a result of TMJ surgery as described in Subsection 4 of the definition of Covered Oral Surgery.
- J. Contact lens exams, prescriptions or fittings of contact lenses or eyeglasses, and the cost of the contact lenses or eyeglasses.
- K. Treatment of myopia and other errors of refraction; orthoptics or visual training; radial keratotomy, including related corrective vision procedures.
- L. Any services or supplies for Routine Foot Care, shoe orthotics, insoles, or shoe inserts of any type unless it constitutes Diabetes Equipment or Diabetes Supplies, as defined herein Article I, Sections AC and AE

Article V Limitations and Exclusions (Continued)

- M. a. Any services or supplies provided to a Participant for Cosmetic, Reconstructive or Plastic Surgery, except for:
1. Surgery performed on a Dependent child under the age of 19 for the treatment or correction of a congenital defect; or
 2. Treatment provided for the correction of defects incurred in an Accidental Injury sustained by the Participant while covered under the Program; or
 3. Treatment provided for reconstructive surgery following neoplastic (cancer) surgery or following a mastectomy.
- b. Coverage is provided for surgical breast reconstruction following a mastectomy to restore or achieve breast symmetry.
- c. Coverage is provided for surgical reconstruction of the breast on which mastectomy surgery was performed and surgical reconstruction of the breast on which mastectomy surgery was not performed.
- N. Any psychiatric or psychological services in the nature of family counseling or marriage counseling, or any self-therapy or therapy to another psychiatrist or Doctor in Psychology as a part of training, or any services of a Master of Science in Social Work who is not a Physician or Other Provider as herein defined.
- O. Travel services or accommodations, whether or not recommended or prescribed by Physician or Other Provider, except Ambulance Services.
- P. Any services or supplies provided to a Participant for treatment of obesity or for weight reduction, weight reduction programs and gym memberships, and surgeries including, but not limited to, Gastric Bypass and Vertical Banding, even if the Participant has medical conditions which might be helped by a reduction of obesity or weight and even if prescribed by a Physician.
- Q. Any services or supplies provided to any Participant for:
- (1) A sterilization reversal;
 - (2) Transsexual surgery;
 - (3) Gender reassignment or
 - (4) Artificial insemination services, or any other type of noncoital reproductive technologies such as in vitro fertilization, gamete intrafallopian transfer, or zygote intrafallopian transfer.
- Also excluded from coverage are any services or supplies used in any procedures performed in preparation for or immediately after any of the above-referenced excluded procedures.
- R. Any services and supplies provided to any Participant in connection with a voluntary interruption of a pregnancy, unless:
- (1) The voluntary interruption of the pregnancy is Medically Necessary where the life of the Participant would be endangered if the fetus were carried to term,
 - (2) The pregnancy is a result of a criminal act such as rape or incest, or
 - (3) There is the presence of a diagnosed fetal anomaly.

Article V Limitations and Exclusions (Continued)

Benefits, however, for treatment of complications arising from or as a result of such voluntary interruption of a pregnancy shall be payable on the same basis as for any other sickness.

- S. Home Infusion Therapy treatment provided by an entity that does not contract with the Claims Administrator or is not accessible through BlueCard Worldwide as a provider of Home Infusion Therapy.
- T. Transplant procedures (including transplantation of non-human organs) or the services performed in preparation for, or in conjunction with such procedure, which the Claims Administrator considers to be Experimental and/or Investigational in nature; living and/or travel expenses of the live donor or recipient; donor search and acceptability testing of potential living donors; expenses related to maintenance of life for purposes of organ tissue donations; purchase of organ or tissue; and donor expenses where donor is not a participant under the Texas Employees Group Benefits Program.
- U. Any Medical Social Services (except as may be provided in Article IV, Sections E, F, and G of the Plan); any bereavement counseling (except as specifically provided in Article IV, Section G, of the Plan); vocational counseling, or Marriage and Family Therapy and/or Counseling.
- V. Items for patient convenience or comfort as determined by the Claims Administrator such as, but not limited to, motorized lifts, over-the-counter splints or braces, air conditioners or purifiers, humidifiers, dehumidifiers, physical fitness and/or whirlpool bath equipment, personal hygiene protection, allergen-free pillows, home air fluidized beds, mattresses, blood pressure cuffs, etc., even if recommended or prescribed by a Physician or Other Provider.
- W. Any services or supplies provided to any Participant:
 - 1. Primarily for:
 - a. Environmental Sensitivity testing or treatment which includes:
 - (a) Controlled environment; or
 - (b) Sanitizing the surroundings, removal of toxic materials; or
 - (c) Use of special nonorganic, nonrepetitive diet techniques; or
 - b. Clinical Ecology testing or treatment which includes:
 - (a) Cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells); or
 - (b) Urine auto injection (injecting one's own urine into the tissue of one's own body); or
 - (c) Skin irritation (Rinkel method); or
 - (d) Sublingual provocative testing (droplets of allergenic extracts are placed in mouth); or
 - (e) Any other treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
 - c. Inpatient allergy testing or treatment.
 - 2. For, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
- X. Any charges for services and supplies provided to a Participant which require Preauthorization by the Claims Administrator when Preauthorization is denied.

Article V Limitations and Exclusions (Continued)

- Y. Any services or supplies provided for Dietary and Nutritional Services, except for an Inpatient nutritional assessment program provided in and by a Hospital and approved by the Claims Administrator or Diabetic Management Services as referenced in Article IV, Section E, Subsection 9 of this Exhibit B.
- Z. Any drugs or medicines purchased for use outside of a Hospital or Facility which require a written or verbal Prescription Order for purchase, other than injectable drugs administered by or under the direct supervision of a Physician or Other Provider. (Prescription drugs are covered under the Prescription Drug Program Supplementary Plan Document attached to and made part of this Master Benefit Plan Document.)
- AA. Any services or supplies for acupuncture.
- AB. Any services or supplies provided before the patient is covered as a Participant under the Plan or any services or supplies provided after the termination of his coverage, except as provided in Article VII of the Plan.
- AC. Any occupational therapy services which do not consist of traditional physical therapy modalities.
- AD. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claims Administrator.
- AE. Any services or supplies provided for, in preparation for, or in conjunction with autologous or allogenic bone marrow transplant with or without high-dose chemotherapy, except for those non-experimental/investigational transplants (as determined and preauthorized by the Claims Administrator) or as may be provided by the Claims Administrator through Case Management.
- AF. Difference between the charges for a Hospital private room and a semiprivate room, excluding coordinating secondary benefits with Medicare Part A.
- AG. Any services or supplies for which benefits are not provided under the Plan.
- AH. Services or supplies provided by a person or entity who is not a Provider, as the term is defined in Article I.
- AI. Any services or supplies provided in connection with a routine physical examination other than:
 - (1) Routine physical examinations as provided in Article IV, Section E of the Plan; and
 - (2) Mammography screening as provided in Article IV, Section E, Subsection 7 of the Plan.

A well-baby examination, including the initial well-baby examination provided during the mother's Hospital stay for the birth of the newborn natural child or the eligible newborn grandchild, is a physical examination for the purposes of this limitation.
- AJ. Any services or supplies for which benefits are, or could upon proper claim be, provided under any other present or future laws enacted by the Legislature of any state, or by the Congress of the United States, or the laws, regulations or established procedures of any county or municipality; provided, however, the exclusions of this Section AJ shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

Article V Limitations and Exclusions (Continued)

- AK. Any services or supplies provided for Behavioral Health Care to any Participant except as provided in Article IV, Section E, Subsection 5, of the Plan.
- AL. Any services and supplies provided for Maternity Care or treatment of Complications of Pregnancy except as provided in Section E, Subsections 1 and 2, of Article IV.
- AM. Physical examination for school admission, insurance, employment, or licensure examination purposes.
- AN. Telemedicine Services performed using a telephone, facsimile machine, or Internet.
- AO. Service, supplies, and related expenses that the Claims Administrator determines to be Experimental and/or Investigational.
- AP. Services and Supplies provided by an Immediate Fb

Article VI Termination of Coverage

- A. The coverage of all Participants under the Plan shall automatically terminate when the Plan is terminated in writing by the Trustee, such termination to be effective on the first day of the Plan Month immediately following notification of cancellation.

- B. The coverage of any Employee or Retiree and his Dependents included under the Plan shall automatically terminate:
 - 1. On the date an Employee's employment terminates; or
 - 2. The day following the last day of the last period for which his portion of the group contribution is paid to the Plan Administrator; or
 - 3. The effective date of an amendment to the Plan which terminates the coverage of any class of Employees or Retirees to which he belongs; or
 - 4. The last day of the Plan Month in which the Employee's or Retiree's death occurs; or
 - 5. The date the Employee or Retiree is expelled from the Texas Employees Group Benefits Program for fraud or attempted fraud; or
 - 6. The end of the Plan Month in which a Participant ceases to be a Participant as defined in Article I, except:
 - a. An eligible member of the Texas Legislature
 - (1) Who held office on or after May 17, 1979, and
 - (2) Who, on ending service as a member of the Legislature, has established the minimum amount of creditable service required of an elective official for eligibility for service retirement benefits at 60 years of age, and
 - (3) Who notified the Plan Administrator within 30 days of leaving office for his intent to continue coverage and remit the necessary premiums therefor; or
 - b. Persons who have at least ten years of creditable service in the Employees Retirement System of Texas as an Employee of the Legislature as defined in State statutes and the rules of the Board of Trustees of the Employees Retirement System of Texas may continue coverage under the Plan for himself or for himself and his family members as Dependents.
 - 7. The last day of the month during which an Employee is on an approved leave of absence without pay status.
 - 8. When this Master Benefit Plan Document is terminated.

- C. The coverage of any Dependent of an Employee or Retiree included under the Plan shall automatically terminate at the end of the Plan Month in which such Dependent ceases to be a Dependent as defined in Article I.

- D. In the event coverage for a Retiree or an Active Employee, who meets the age and service credit requirements to qualify for a retirement benefit or a survivor's annuity, ends by reason of death, a

Article VI Termination of Coverage (Continued)

surviving Dependent of the deceased shall have the right to continue coverage under the Plan provided:

- (1) Each Dependent continues to be an eligible Dependent as defined herein; and
 - (2) Payment of contributions is made to the Employees Retirement System of Texas according to its administrative rules and practices.
- E. Under no circumstances shall the Claims Administrator be obligated to notify any Participant of the termination of the Plan or of his coverage under the Plan.

Article VII Extension of Benefits

In the event a Participant's coverage under the Plan terminates, benefits will be extended subject to the following terms and provisions:

Any Employee, Retiree, or Dependent who is Totally Disabled, as defined in Article I, on the effective date of the termination of the Plan pursuant to Article VI, Section A, and whose coverage ceases because of termination of the Plan, shall be entitled to receive benefits for Inpatient Hospital Expense, Extended Care Services, and Other Medical Expense, in accordance with the Plan, subject to the benefit limitations and maximums, for the continued treatment of the condition causing the Total Disability, such benefits to be available for the period of the Total Disability or for 90 days following the Plan termination date, whichever is less. However, if the Plan is replaced with coverage issued by a Succeeding Plan which provides substantially equivalent or greater benefits than those provided by the Plan, this extension of benefits for Total Disability is not applicable.

A definition applicable to this Article VII:

“Succeeding Plan” means a plan that has replaced the coverage of the Plan with its coverage.

Article VIII Option to Continue Group Coverage and Conversion Privilege

A. Continuation of Group Coverage

1. If under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, any Participant is granted the right to continuation of coverage beyond the date his coverage would otherwise terminate, the Plan shall be deemed to allow continuation of coverage to the extent necessary to comply with the provisions of the statute, subject to the following special provisions.
2. Timely payment of the contribution rate for all contribution payment periods is required to continue the coverage. The Plan Administrator shall collect the proper contributions from all continued Participants for each contribution payment period.
3. As long as the Plan is not terminated, if continued coverage is elected, such coverage shall automatically terminate after the expiration of the maximum period required in the statute; provided, however, should any fact(s) occur which is specified in the statute as shortening the maximum period required for continued coverage, the continued coverage automatically shall terminate upon the occurrence of such fact(s).
4. The Claims Administrator shall not be considered the agent of the Employer or Plan Administrator and shall not be responsible for the performance of any duty imposed on them by any applicable statute.
5. If the Plan replaces a group health care plan of the Employer and any person acquired rights to continuation of coverage under the statute prior to the Plan Effective Date for a period of time that has not expired on the Plan Effective Date, such person shall be entitled to the rights of a continued Participant under the Plan for the remainder of such period, provided he complies with all requirements of this Article VIII during the period of continued coverage under the Plan.

B. Conversion Privilege

1. When coverage for any Participant is terminated under Article VI or Section A of this Article VIII, the Participant shall have the right of conversion to new individual coverage on an insured basis as provided in Subsection 2, below.
2. Any Participant becoming eligible for conversion as provided for in the preceding Subsection 1 may, within 31 days after termination of his coverage under the Plan, submit application for new individual hospitalization and medical-surgical coverage under the form or forms of contracts then offered by the Carrier to conversion applicants. The contract applied for will be issued, without requirement of Evidence of Insurability, at the conversion premium rates then in effect. Premiums and benefits of the individual contract shall be quite different from those provided by the prior group coverage. The individual contract will be made effective as of the day after the date of the termination under the Plan, and full recognition will be extended to the period of coverage under the Plan for the satisfaction of waiting periods and clauses respecting any Preexisting Condition as may be contained in such individual contract.

“Carrier,” for purposes of this Subsection 2, means the insurer or insurers designated by the Plan Administrator to provide individual insurance coverage to Participants electing such insurance upon termination of coverage under the Plan as provided in this Section B.

Article IX General Provisions

- A. **Applicable Law:** The Plan is issued in Texas and is subject to Texas law. All disputes arising under this Master Benefit Plan Document shall be resolved in accordance with Subchapter H (Sections 1551.351 through 1551.360) of the Act and in accordance with the Rules adopted by the Board of Trustees, and any appeal shall be made to the District Court in Travis County, Texas.
- B. **Claim Denial and Appeal:**
1. Normal Appeals Process:
 - a. In the event a claim for benefits under the Plan is denied, the Employee or Retiree will be provided an explanation in writing setting forth the specific reasons for the denial.
 - b. If the Employee or Retiree does not agree with a claim denial, he may request that a review be made of the claim. The request may be submitted to the Claims Administrator in writing. Additional information may be submitted with the request for review.
 - c. If the claim is again denied, the Claims Administrator will furnish instruction to the Employee or Retiree on how to file a grievance with ERS. Should the Employee or Retiree wish to file a grievance, the grievance must be in writing and served on ERS within 90 days of the date the Claims Administrator serves notice of grievance rights on the Employee or Retiree. Service and filing of grievances, notices, denials, explanations and the like is complete upon the mailing of the paper to the Employee, Retiree, or ERS. After a grievance is filed with ERS, ERS will serve a decision on the Employee or Retiree.
 - d. Grievance and appeal rights are not provided with respect to plan design issues, including by not limited to, the terms of the Master Benefit Plan Document, the scope of coverage provided in the Master Benefit Plan Document, Prior Authorization determinations under Exhibit C, Article I.AA and Quantity Limitation determinations under Exhibit C, Article I.BB.
 2. Review by an Independent Review Organization (IRO):
 - a. HealthSelect shall permit any party whose request for preauthorization of the medical necessity of proposed treatment has been denied, and BCBSTX has sustained the determination, to seek review of that determination by an IRO whether or not a life-threatening condition is involved. In the case of inpatient treatment, IRO review shall be permitted on a concurrent basis if coverage for continued inpatient treatment has been denied as not medically necessary, and BCBSTX has sustained the determination. An IRO will be assigned as follows:
 - (1) BCBSTX shall provide to Participant, Participant's designated representative, or Participant's provider of record, information on how to obtain review of an Adverse Determination to an IRO;
 - (2) Such information must be provided by BCBSTX to Participant, Participant's designated representative, or Participant's provider of record at the time of the Adverse Determination. If such information is provided to the Participant's provider of record, a copy must be furnished to the Participant;

Article IX General Provisions (Continued)

- (3) BCBSTX shall provide to Participant, Participant's designated representative, or Participant's provider of record the prescribed form;
 - (4) The form must be completed by Participant, Participant's designated representative, or Participant's provider of record and returned to BCBSTX to begin the independent review process;
 - (5) In life-threatening situations, Participant, Participant's designated representative, or Participant's provider of record may contact BCBSTX by telephone to request the immediate review and provide the required information.
- b. In a circumstance involving a life-threatening condition, the Participant is entitled to an immediate review by an IRO and is not required to first comply with the normal appeals process described in Subsection 1 above.
 - c. The IRO review process does not prohibit Participant from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment or relief available under law, if the requirement of exhausting the process for IRO review places the Participant's health in serious jeopardy.
 - d. The Participant may still appeal an incurred denied claim by following the normal appeal procedures described in Subsection 1 above.
 - e. Review by an IRO is not available for contract exclusions, regardless of whether the proposed treatment would be medically necessary were it not a contract exclusion.
- C. **Claim Forms:** The Employee or Retiree, the Hospital, and/or the Participant's Physician or Other Provider will be furnished, upon receipt by the Plan of a notice of claim or prior thereto, such forms as are usually furnished for filing Proof of Loss.
- D. **Copies; Plan Information:** Any Employee or Retiree may obtain copies of this Master Benefit Plan Document and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies. Such copies will be supplied within 30 days. Copies of all Plan documents may also be inspected at any time during normal working hours by any Participant.
- E. **Coverage Data:** The Plan Administrator shall furnish the Claims Administrator all information needed to effect coverage of Employees or Retirees and Dependents under the Plan and termination and changes in such coverage on a timely basis.
- F. **Disclaimer:** Neither the Plan nor the Claims Administrator shall be liable for any act or omission by any Hospital, Facility, Physician, or Other Provider, their agents or employees, in caring for a Participant receiving services covered under the Plan, and no responsibility attaches hereunder for inability of any Hospital, Facility, Physician, or Other Provider to furnish accommodations or services. Benefits for such services 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.
- G. **Disclosure Authorization:** In consideration of the Claims Administrator having waived physical examination in connection with his application for coverage under the Plan, the Employee or Retiree, on behalf of himself and his covered Dependents, shall be deemed to have authorized any Hospital,

Article IX General Provisions (Continued)

Physician, or Other Provider, insurance carrier, or other entity to furnish the Claims Administrator all information and records or copies of records relating to the diagnosis, treatment, or care of any Participant included under his coverage; and such Participants shall, by asserting claim for benefits under the Plan, be deemed to have waived all provisions of law forbidding the disclosure of such information and records.

- H. **Funding:** The Plan is funded through the state of Texas Employees Life, Accident, and Health Insurance and Benefits Fund and the participating Employees and Retirees in accordance with Section 1551.401 and 1551.405 of the Act.
- I. **Gender:** Use herein of a personal pronoun in the masculine gender shall be deemed to include the feminine unless the context clearly indicates the contrary.
- J. **Legal Actions:** No action at law or in equity shall be brought to recover on the Plan prior to the expiration of 60 days after written Proof of Loss has been filed in accordance with the requirements herein. 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 the Plan.
- K. **Master Benefit Plan Document; Amendments:**
1. The Master Benefit Plan Document and the Schedule of Specifications herefor, a copy of which is attached hereto, shall constitute the entire document.
 2. This Master Benefit Plan Document may be amended or changed at any time by the Trustee upon 30 days prior written notice to the Claims Administrator, subject to the laws of the jurisdiction in which it is delivered, without the consent of the Employees or Retirees covered under the Plan or of their beneficiaries.
- L. **Medicare/Primary Carrier Determinations:** Any exclusions of benefits in this Master Benefit Plan Document for services or supplies for which benefits are paid or payable under governmental programs and the definition of "Health Plan" in Article III, Section C, of the Plan shall not be applicable to Medicare Part A and Part B benefits for those Employees or Retirees who the Employer determines are Employees or Retirees 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 or Retirees 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 "Health Plan" described above are not applicable to Medicare Part A and Part B benefits for Participants who are in the first 12 months of Medicare entitlement for treatment of end-stage renal disease due to kidney transplant or self-dialysis training or who are in the first nine months of Medicare entitlement by reason of renal dialysis.
- M. **Not a Contract:** The Plan shall not be deemed to constitute a contract between the Employer and any Employee, Retiree or Dependent, or to be a consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer, or to interfere with the right of the Employer to discharge any Employee at any time.
- N. **Notice of Claim:** The Employee or Retiree shall give or cause to be given written notice to the Plan through the Claims Administrator, its duly authorized agent, within 30 days or as soon as reasonably possible after any Participant receives any of the services for which benefits are provided in the Plan.

Article IX General Provisions (Continued)

- O. **Physical Examinations and Autopsy:** The Plan shall have the right and opportunity to have the person of the Participant, for whom claim is made, examined when and so often as it may reasonably require during the pendency of a claim under the Plan and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.
- P. **Proof of Loss:** Except for services or supplies provided by a Hospital, written Proof of Loss must be furnished to the Claims Administrator at its designated office, or to its duly authorized agent, no later than 18 months from the date that the services or supplies are provided to the Participant. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to furnish such proof within such time due to absence of legal capacity of the Employee or Retiree.
- Q. **Refund of Benefit Payments:** If and when the Plan determines that benefit payments under the Plan have been made erroneously but in good faith, the Plan reserves the right to seek recovery of such benefit payments from the Participant, or Provider of services to whom such payments were made. The Plan reserves the right to offset subsequent benefit payments otherwise available by the amount of any such overpayments.
- R. **State Government Programs:**
1. Benefits for services or supplies under the Plan will not be excluded solely because benefits are paid or payable for such services or supplies under a state plan for medical assistance (Medicaid) made pursuant to 42 U.S.C., Section 1346 et seq., as amended. Any benefits payable under such state plan for medical assistance shall be payable to the Texas State Department of Human Services to the extent required by Article 21.49-10 of the *Texas Insurance Code*.
 2. All benefits paid on behalf of a child or children under the Plan must be paid to the Texas Department of Human Services where:
 - a. The Texas Department of Human Services is paying benefits pursuant to Chapter 31 or 32 of the Human Resources Code, and
 - b. The parent who is covered by the Plan has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support, and
 - c. The Claims Administrator receives written notice at its Home Office, affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services.
- S. **State or Federal Law:** In all situations deemed applicable by the Employees Retirement System of Texas and where state or federal laws or regulations mandate specific terms or provisions which conflict with specific terms or provisions of the Master Benefit Plan Document or Rules, the Master Benefit Plan Document and appropriate Rules shall be interpreted and administered to comply with such laws or regulations.

Article IX General Provisions (Continued)

T. Subrogation/Right of Recovery:

- a. This provision applies when another party (person or organization) is or may be considered responsible for payment because of a Participant's injury or sickness for which benefits under the Plan have been provided.
- b. To the extent of such services provided, the Plan is subrogated to all rights of recovery the Participant has and the Plan may assert such rights independent of the Participant. Also, if the Participant has obtained or obtains a court judgment, settlement, arbitration, award, or other monetary recovery from another party, because of the injury or sickness, the Plan is entitled to reimbursement from the proceeds of recovery to the extent of benefits provided. If a recovery is made, the Plan shall have first priority over the Participant or any other party to receive from said recovery reimbursement of the benefits the Plan has provided. This priority shall apply and reimbursement shall be required:
 1. Even though the third-party payment does not compensate the Participant for his or her whole loss;
 2. Whether or not liability for payment is admitted by the third-party;
 3. Whether or not such recovery is itemized or called anything other than a recovery for medical expenses incurred;
 4. From any recovery, including but not limited to, uninsured or underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), worker's compensation settlements or awards, other group insurance including student plans and direct recoveries from liable parties.
- c. The Participant is obligated to cooperate with the Plan to protect its subrogation rights and shall not prejudice the Plan's right of recovery and reimbursement. Failure to cooperate or prejudice the Plan's rights shall occur if the Participant fails to:
 1. Complete a third-party information report, naming, among other things:
 - (a) The party who may be considered responsible for the injury or sickness;
 - (b) Any current or anticipated third-party litigation, settlement negotiations, or other coverage;
 - (c) The name, address and telephone number of any attorney retained by the Participant to prosecute a third-party claim;
 - (d) The name, address, and telephone number, claim number, or policy number, as known to the Participant of any insurance companies insuring either the Participant, the third-party or others liable for payment to the Participant on account of his or her injuries;
 2. Give statements and provide information about the other parties or the injury or sickness when requested by the Plan;
 3. Execute and deliver any other documents or do whatever else the Plan reasonably requires to secure its rights of subrogation;

Article IX General Provisions (Continued)

4. Obtain the Plan's consent prior to releasing the third-party from liability for payment of medical expenses; or
 5. Reimburse the Plan when a recovery is made from any source as a consequence of third-party negligence or other actions.
- d. In the event that the Participant fails to cooperate with the Plan or prejudices its subrogation rights, the Plan may deduct from any pending or subsequent claim made under the Plan any amounts the Participant owes the Plan until such time as cooperation is provided or the prejudice ceases.
 - e. No beneficiary hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically, no courts costs nor attorney's fees may be deducted from the Plan's recovery without the prior express written consent of the Plan. This right shall not be defected by any so-called "Fund Doctrine," or "Common Fund Doctrine," or "Attorneys Fund Doctrine."
 - f. The Plan shall recover the full amount of the benefits paid hereunder without regard to any claim of fault on the part of any beneficiary, whether under comparative negligence or otherwise.
- U. **Time of Payment of Claims:** A valid claim for benefits available under the Plan for any loss will be paid not more than 60 days after receipt of written Proof of Loss.
- V. **Workers' Compensation Insurance:** The Plan is not in lieu of, is not in any way subject to, and does not affect any requirement for coverage by Workers' Compensation Insurance.

Schedule of Specifications

The Schedule of Specifications set out herein shall apply to the Master Benefit Plan Document for the Comprehensive Medical Care Plan (Out-of-Area Benefits) portion of HealthSelect. The account number shall be 38000-B and the effective date of this Schedule of Specifications is September 1, 2003.

Schedule of Specifications	
	Out-of-Area Benefits
In-Patient Hospital Expense Benefits	
1. Benefit percentage of allowable amount	70%
a. Preadmission testing Services	70%
b. Preauthorization penalty Deductible each Hospital Admission (waived if admission is preauthorized)	\$200
c. Inpatient Copayment amount (not to exceed \$500 per admission)	\$100 per day
Other Medical Expense Benefits	
2. Benefit percentage of allowable amount	70%
a. Deductible each Participant each Calendar Year	\$200
b. Family Deductible each Calendar Year (three family members)	\$600
c. Outpatient Day-Surgery copayment	\$100
3. Infertility Services (See Article V, Q for excluded services)	70%
Other Benefit Provisions	
4. Maternity Care Benefits	
a. All Participants are eligible for Maternity Care benefits and benefits for treatment of Complications of Pregnancy	70%
b. Benefits for Covered Services and Supplies are considered on the same basis as for treatment of any sickness	-----
5. Serious Mental Illness Benefits	
Benefits for Covered Services and Supplies are considered on the same basis as for treatment of any sickness	-----
6. Behavioral Health Care Benefits	
a. Inpatient Hospital Expense:	
(1) Maximum number of days each Calendar Year	30*
(2) Inpatient Copayment amount (not to exceed \$500 per admission)	\$100 per day
(3) Benefit percentage:	
(a) First 15 days	70%
(b) Next 15 days	50%
b. Psychiatric Intermediate Care Facility:	
(1) Maximum number of days each Calendar Year	60*
(2) Inpatient Copayment amount (not to exceed \$500 per admission)	\$50 per day
(3) Benefit percentage:	
(a) First 30 days	70%
(b) Next 30 days	50%

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**

Schedule of Specifications

Other Benefit Provisions	Out-of-Area Benefits
c. Other Medical Expense: (1) Maximum Inpatient Physician or Other Provider visits each Calendar Year (a) Benefit percentage first 15 visits (b) Benefit percentage next 15 visits	30* 70% 50%
(2) Maximum Outpatient Physician or Other Provider visits each Calendar Year (a) Benefit percentage (b) Maximum allowed for Covered Services and Supplies not to exceed \$60 per visit	30* 70%
7. Substance Abuse Treatment Benefits Benefits for Covered Services and Supplies are determined on same basis as for treatment of sickness	-----
8. Private-Duty Nursing: a. Benefit percentage for Other Medical Expense b. Maximum benefit each Calendar year c. Maximum lifetime benefit d. Preauthorization required	70% \$8,000* \$40,000*
9. Mammography Screening Benefits Benefit percentage for Other Medical Expense	70%
10. Hearing Aid Benefits a. Benefit percentage b. Maximum benefit per ear for any consecutive three-year period	100% \$500*
11. Skilled Nursing Care in a Skilled Nursing Facility a. Benefit percentage b. Maximum number of days each Calendar Year, Or maximum benefit each Calendar Year (whichever occurs first) c. Deductible waived d. Preauthorization required	100% 60* \$6,000*
12. Home Health Care Benefits a. Benefit percentage b. Maximum number of visits each Calendar Year, Or maximum benefit each Calendar Year (whichever occurs first) c. Deductible waived d. Preauthorization required	100% 100* \$5,000*
13. Hospice Care Benefits a. Benefit percentage b. Maximum lifetime benefit c. Deductible waived d. Preauthorization required	70% \$18,000*
14. Home Infusion Therapy Benefits a. Benefit percentage for Other Medical Expense b. Preauthorization required	70%

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**

Schedule of Specifications

	Out-of-Area Benefits
15. Prescription Drug Program	
Plan year Prescription Drug Deductible	\$50 per person, per Plan Year
Participating pharmacies (non-maintenance, up to a 30-day supply)	\$10 for generic; \$25 for preferred brand name; \$40 for non-preferred brand name. **
Participating pharmacies (maintenance, up to a 30-day supply)	\$15 for generic; \$35 for preferred brand name; \$55 for non-preferred brand name. **
Non-Participating pharmacies (up to a 30-day supply)	60% of the lesser of: the amount Participant pays for the prescription, minus the copayment OR the average wholesale price of the drug, plus the dispensing fee, minus the copayment. **
Mail Order pharmacy (up to a 90-day supply)	\$30 for generic; \$75 for preferred brand name; \$120 for non-preferred brand name. **

****If a brand-name drug is dispensed that has a generic available, in addition to paying the generic copayment, participants will also be responsible for the difference in the cost between the generic and the preferred or non-preferred brand name drug.**

Schedule of Specifications	
	Out-of-Area Benefits
Coinsurance Stop-Loss (Out-of-Pocket Coinsurance Maximum)	
16. Coinsurance amount per Participant, per Calendar Year	\$1,000
Inpatient Copayment Stop-Loss	
17. Inpatient Copayment Maximum per Participant, per calendar year for network, non-network, and out-of-area benefits	\$1,500
Maximum Lifetime Benefits	
18. Maximum lifetime benefit for each Participant	No limit

***Includes all Network Benefits, Non-Network Benefits and Out-of-Area Benefits**

Plan Effective Date

The Plan Effective Date is September 1, 2003. The Plan and the coverage provided therein shall become effective on the Plan Effective Date stipulated above.