Your Health Care Benefit Program

Ector County ISD
Group #04843

In Hospital Indemnity Plan

Administered by:

BlueCross BlueShield of Texas

## Schedule of Coverage

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>Daily allowance</td>
<td>$300</td>
</tr>
<tr>
<td>Benefit days available per period of bed-patient</td>
<td></td>
</tr>
<tr>
<td>Regular Admissions (includes Chemical Dependency)</td>
<td>60 days</td>
</tr>
<tr>
<td>Special Admissions - Mental Health</td>
<td>60 days</td>
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This benefit is available for Employees only. Dependents are not eligible for coverage.
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INTRODUCTION

EXPLANATION

This booklet summarizes the Group In-Hospital Indemnity Plan issued to your Employer. Please read this booklet carefully so you will be aware of the benefits and requirements of the Plan. The booklet includes definitions of terms you should know and detailed information about your coverage. The booklet is not the entire Plan itself, but is a component of the Plan. In the event of any conflict between any components of the Plan, the Schedule of Specifications provided to your Employer by BCBSTX prevails.

The daily Hospital room allowance and number of benefit days which apply to your coverage are shown on the Schedule of Coverage.

CUSTOMER SERVICE HELPLINE

Your Customer Service Representative can:

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

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

The Helpline Number is:
1-800-521-2227
ELIGIBILITY REQUIREMENTS FOR COVERAGE

The Eligibility Date is the date a person becomes eligible to be covered under the Plan. A person becomes eligible to be covered when he becomes a Participant and is in a class eligible to be covered under the Plan. The Eligibility Date is the date the Participant completes the Waiting Period (the number of days of continuous employment required by the Employer), if any, for coverage.

Employee Eligibility
You are eligible for coverage under the Plan if you are an Employee as described in DEFINITIONS in this Benefit Booklet. You may apply for coverage on or before your Eligibility Date.

EFFECTIVE DATES

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

Actively at Work/Non-Confinement Requirements
Coverage under the Plan will become effective as explained below, but only if you have satisfied the Actively at Work/Non-Confinement requirements on the date coverage is to become effective. Refer to DEFINITIONS in this Benefit Booklet for an explanation of “Actively at Work/Non-Confinement.” If you have not satisfied the Actively at Work/Non-Confinement requirements on the date coverage would otherwise become effective, the coverage will become effective on the date following the first day you satisfy the requirements.

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

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

2. Become eligible after the Plan Effective Date and the application is received by the Claims Administrator through the Plan Administrator within the first 31 days following your Eligibility Date, the coverage will become effective as provided in the Plan (see your Employer for this Effective Date information).

Late Applicants
If you apply for coverage for yourself and the application is received by the Claims Administrator through the Plan Administrator more than 31 days following your Eligibility Date, see your Employer for this Effective Date information. Several Effective Date options are available for late applications.
**BENEFITS PROVIDED**

If you receive Care as a bed patient in a Hospital, a Facility, or a U. S. military medical treatment facility, benefits will be provided as described below:

**Daily Allowance**

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

The daily allowance for days of confinement in the intensive care unit and/or coronary care unit of a Bed-Patient Admission is specified on the Schedule of Coverage.

**Number of Benefit Days**

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

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

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

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

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

5. For all Bed-Patient Admissions during any one Period of Bed-Patient Confinement, the maximum number of benefit days available for that Period of Bed-Patient Confinement will be the number specified on the Schedule of Coverage. The daily allowance will also apply to admissions for Mental Health Care, Serious Mental Illness, and Treatment of Chemical Dependency.

For purposes of this Plan, the following will apply:

1. The term “regular Bed-Patient Admissions” will apply to all Bed-Patient Admissions except for admissions for Mental Health Care or for treatment of Chemical Dependency. Admissions for treatment of Serious Mental Illness and treatment of Chemical Dependency will be considered “regular Bed-Patient Admissions.”

2. The term “special Bed-Patient Admissions” will apply to admissions for either Mental Health Care or treatment of Chemical Dependency, or both, as specified in the Schedule of Coverage.

**CHANGES IN BENEFITS**

Changes in benefits will apply to all services provided to each Participant under this Plan on and after the Effective Date of the changes. If the benefits increased and if the Participant has not satisfied the Actively at Work/Non-Confinement requirement on the day the amount of his coverage would otherwise be increased, such increase shall not become effective until the date following the first day the Participant does satisfy such requirement.

Benefits for Bed-Patient Admissions commencing before the effective date of the changes in benefits will be under the terms of the benefits in effect at the commencement of the Bed-Patient Admission.

**CLAIM FILING PROCEDURES**

**Filing of Claims Required**

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

**Who Files Claims**

You must submit your own claims to the Claims Administrator using a form provided by the Claims Administrator. Your Employer should have a supply of these forms or you may contact the Customer Service Helpline for assistance. Include the itemized bill from the...
HOW TO RECEIVE BENEFITS

Hospital or Facility showing the dates of service and the name of the Participant involved.

After all information has been completed, please mail the claim form with attachments to:

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

Who Receives Payment

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

If you owe the Plan any sums, the Plan may deduct from its benefit payment the amount that it is owed. Payment to you (or deduction by the Plan from payments to you) of amounts owed to the Plan will be considered to satisfy its obligations to you under the Plan.

An Explanation of Benefits summary is sent to you.

Form of Claims

All claims must be in writing and on forms furnished by the Claims Administrator. Claim forms may be obtained from your Employer. All claims must contain all of the information required by the Claims Administrator on the form. If it does not, the Claims Administrator cannot process the claim.

When Claims Must Be Submitted

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

Receipt of Claims by the Claims Administrator

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

Review of Claim Determinations

Claim Determinations

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

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

If a Claim Is Denied or Not Paid in Full

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

If the claim is denied in whole or in part, you will receive an Explanation of Benefits (EOB) summary or a letter of denial, from the Claims Administrator with the following information, if applicable:

The reasons for denial:
• A reference to the health care plan provisions on which the denial is based;
• A description of additional information which may be necessary to complete the claim and an explanation of why such information is necessary; and
• An explanation of how you may have the claim reviewed by the Claims Administrator, if you do not agree with the denial.
Right to Review Claim Determinations
You have the right to seek and obtain a full and fair review of any determination of a claim or any other determination made by the Claims Administrator in accordance with the benefits and procedures detailed in your Health Benefit Plan.

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

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

  **Claims Review Section**  
  **Blue Cross and Blue Shield of Texas**  
  **P. O. Box 660044**  
  **Dallas, Texas 75266-0247**

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

- The Claims Administrator will honor telephone requests for information, however, such inquiries will not constitute a request for review.

- You and your authorized representative may ask to see documents relevant to the denial or partial denial and may submit written issues, comments and additional medical or dental information within 180 days after you receive notice of a denial or partial denial. The Claims Administrator will give you a written decision within 60 days after it receives your request for review.

- If you have any questions about the claims processing procedures or the review procedure, write to the Claims Administrator or call the toll-free Customer Service Helpline number shown in this Benefit Booklet or on your Identification Card.

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

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

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

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

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

If you have a claim for benefits which is denied or ignored, in whole or in part, and your Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.
LIMITATIONS AND EXCLUSIONS

The benefits of the Plan are not available for:

1. Any Bed-Patient Admission which commences before the patient is covered as a Participant under this Plan or after the termination of his coverage.

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

3. Any Care other than a Bed-Patient Admission in an accredited or duly licensed, or certified Facility, Hospital, or U.S. military medical treatment Facility.

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

5. Custodial Care.

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

As used in this booklet:

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

As applied to you:

- The active expenditure of time and energy in the service of the Employer at your usual and customary place of employment;
- You must be physically and mentally capable of performing on a regular basis all of the usual and customary duties required for your position; and
- You will be considered to be Actively at Work on each day of a regular paid vacation, or a regular non-working day (on which you are not Totally Disabled) if you are Actively at Work on the last scheduled working day preceding such vacation or non-working day.

The person will not be considered to have satisfied the Actively at Work/Non-Confinement requirements if they are:

- Totally Disabled;
- Confined to any institution; or
- At home under medical Care, to a point of not being able to carry on any of the normal duties or activities of a person in good health who is the same sex and approximate age.

**Bed-Patient Admission** means the period between the time of a Participant's entry into a Hospital or Facility as a Bed-patient and the time of discontinuance of Bed-patient Care or discharge by the admitting Physician, whichever first occurs. The day of entry, but not the day of discharge or departure, shall be considered in determining the length of a Bed-Patient Admission.

If 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 Bed-Patient Admission by BCBSTX.
DEFINITIONS

• licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Claims Administrator means Blue Cross and Blue Shield of Texas (BCBSTX). BCBSTX, as part of its duties as Claims Administrator, may subcontract portions of its responsibilities. Claims Administrator may also mean any successor named by the Plan Administrator.

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

Custodial Care means Care comprised of room and board and other institutional services provided to 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.

Eligibility Date means the date the applicant satisfies the definition of Employee and is in a class eligible for coverage under the Plan as described in ELIGIBILITY REQUIREMENTS FOR COVERAGE in this Benefit Booklet.

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

Employer means, in addition to the person, firm, or institution named on the front of this booklet, one or more subsidiaries or affiliates, if any, listed in the Special Provisions section of the Schedule of Specifications portion of the Plan.

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

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

As used herein, medical treatment includes medical, surgical, or dental treatment. Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

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

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

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

Facility means a Crisis Stabilization Unit or Facility, a Psychiatric Day Treatment Facility, a Chemical Dependency Treatment Center, or any other facility which is appropriately licensed and accredited, and which furnishes Care to a Participant as described in the BENEFITS PROVIDED portion of this booklet.
DEFINITIONS

Hospital means a short-term acute Care facility which:

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

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

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

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

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

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

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

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

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

3. Not primarily for the convenience of the Employee, his Physician, the Hospital or the Provider; and

4. The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant.

5. When applied to hospitalization, this further means that the Participant requires acute Care as a bed patient due to the nature of the services provided or the Participant’s condition, and the Participant cannot receive safe or adequate Care as an outpatient.

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

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

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

2. The diagnosis or treatment of any symptom, condition, disease or disorder by a Physician or other Provider (or by any person working under the direction or supervision of a Physician or Provider) when the Eligible Expense is:
   a) Individual, group, family or conjoint psychotherapy,
   b) Counseling,
   c) Psychoanalysis,
   d) Psychological testing and assessment,
   e) The administration or monitoring of psychotropic drugs, or
   f) Hospital visits or consultations in a facility listed in subsection 5, below;

3. Electroconvulsive treatment;

4. Psychotropic drugs;

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

**Participant** means an individual whose coverage has become effective under this Contract.

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

**Physician** means a person, when acting within the scope of his license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the *Texas Insurance Code*.

**Plan Administrator** means the Group Health Plan (GHP) or a named administrator of the GHP having fiduciary responsibility for its operation. Under no circumstances shall BCBSTX be considered the fiduciary to the GHP, its Participants, or the Plan Administrator.

**Plan Effective Date** means the date on which coverage for the Employer’s Plan with BCBSTX commences.

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

**Provider** means a Hospital, Physician, or any other person, company, or institution furnishing to a Participant an item of service or supply listed when acting within the scope of his license and that is appropriately certified.

**Psychiatric Day Treatment Facility** means an institution which is appropriately licensed and is accredited by the Joint Commission on Accreditation of Healthcare Organizations as a Psychiatric Day Treatment Facility for the provision of Mental Health Care 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.

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

1. bipolar disorders (hypomanic, manic, depressive, and mixed);
2. depression in childhood and adolescence;
3. major depressive disorders (single episode or recurrent);
4. obsessive-compulsive disorders; and
5. paranoid and other psychotic disorders;
6. pervasive developmental disorders;
7. schizo-affective disorders (bipolar or depressive); and
8. schizophrenia.

**Total Disability** or **Totally Disabled** means, as applied to an Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of his occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned prior to disability.
GENERAL INFORMATION

NONASSIGNMENT

Rights and benefits under the Plan shall not be assignable, either before or after Care is provided.

REFUND OF BENEFIT PAYMENTS

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

INFORMATION CONCERNING THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

If the coverage is part of an “employee welfare benefit plan” and “welfare plan” as those terms are defined in ERISA:

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

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

3. Claims for benefits must be made in writing on a timely basis in accordance with the provisions of the Plan. Claim filing and claim review procedures are found in the HOW TO RECEIVE BENEFITS section of this booklet.

4. BCBSTX, as the Claims Administrator, is not the ERISA “plan administrator” for benefits or activities pertaining to the Plan.

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

6. The Plan Administrator has given the Claims Administrator the initial authority to make certain benefit determinations in accordance with the benefits and procedures detailed in the Health Benefit Plan.

The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan’s provisions and determining questions of eligibility and benefits. Any decision made by the Plan Administrator shall be final and conclusive.

TERMINATION OF COVERAGE

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

Termination of Individual Coverage

Coverage under the Plan for you will automatically terminate when:

1. Your portion of the group contribution is not received timely by the Claims Administrator; or

2. Your employment terminates; or

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

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

Termination of the Group

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