TEXAS
Health Insurance Pool

Policy and Medical Claims Administered By:
Blue Cross and Blue Shield of Texas*
P. O. Box 660819
Dallas, TX 75266
Toll Free Number: 1-888-398-3927
(Administrator)

Pharmacy Program Administered By:
Medco Health Solutions, Inc.
100 Parsons Pond Drive
Franklin Lakes, NJ 07417
Toll Free Number: 1-800-290-1708
(Pharmacy Manager)

This Policy is issued in consideration of the application and the payment of premium. We agree to provide the benefits of the Policy for Covered Expenses incurred by the Insured Persons. The effective date of coverage is shown in the Policy Schedule. A copy of Your application is attached.

TABLE OF CONTENTS

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

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Texas Health Insurance Pool's toll-free telephone number for information or to make a complaint at:

1-888-398-3927

You may also write to:

Texas Health Insurance Pool
P. O. Box 660819
Dallas, TX 75266

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:
P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:
Should You have a dispute concerning Your premium or about a claim You should contact Texas Health Insurance Pool first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY/CERTIFICATE:
This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Texas Health Insurance Pool's para informacion o para someter una queja al:

1-888-398-3927

Usted tambien puede escribir a:

Texas Health Insurance Pool
P. O. Box 660819
Dallas, TX 75266

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:
P.O. Box 149104
Austin, TX 78714-9104
Fax: (512) 475-1771
Web: http://www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el Texas Health Insurance Pool primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

UNA ESTE AVISO A SU POLIZA/CERTIFICADO:
Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

SECTION 1. 10-DAY RIGHT TO EXAMINE POLICY

Please read Your Policy. If You are not satisfied, send it back to the Administrator within 10 days after You receive it. The Policy will be voided and any premium paid returned to You.

SECTION 2. PLEASE READ APPLICATION

Please read the copy of Your application. If anything is not correct, You should tell the Administrator. The Policy was issued on the basis that all information in the application is correct and complete. If not, Your Policy may not be valid.

SECTION 3. ELIGIBILITY FOR COVERAGE

a. You are eligible for coverage by the Pool if You are and remain a legal resident of Texas and You provide evidence that You are a Federally Defined Eligible Individual who has not experienced a Significant Break in Coverage.

b. You are eligible for coverage by the Pool if You are under age 65, You are and remain a legal resident of Texas, and You provide evidence that You maintained Health Benefit Plan coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because You no longer resided in that state, provided You submit an application for Pool coverage no later than the 63rd day after such other coverage was terminated.

c. You are eligible for coverage by the Pool if You are under age 65 (or over the age of 65 and not enrolled in Medicare Part B), and remain a legal resident of Texas and You provide evidence that You are certified as eligible under Trade Adjustment Assistance or the Pension Benefit Guaranty Corporation (collectively, the HCTC Program).

d. You are also eligible for coverage by the Pool if You are under age 65, have been for at least 30 days and remain a legal resident of Texas and a United States citizen or a permanent legal resident of the United States for at least three continuous years, and You provide evidence of one of the following to us:

1. A notice of rejection or refusal by an Insurance Company to issue substantially similar individual Health Benefit Plan coverage to You for health reasons;

2. A certification from an agent or salaried representative of an Insurance Company, on the Pool's Application form, that states the agent or representative is unable to obtain substantially similar individual Health Benefit Plan coverage for You with any state-licensed Insurance Company, which the agent or representative represents, because You will be declined for coverage, as a result of Your medical condition, under the underwriting guidelines of the Insurance Company;

3. An offer by an Insurance Company to issue substantially similar individual Health Benefit Plan coverage to You only with conditional riders, which exclude coverage for medical conditions; or

4. You have been diagnosed with one of the medical conditions determined as a condition for automatic eligibility by the Board of Directors of the Pool.

e. Your Dependents are also eligible for coverage by the Pool. If the eligible individual is a child who enrolls for Pool coverage, Family Members of the child, who reside with the child, are also eligible for coverage by the Pool. Your Dependents and a child's Family Members, as applicable, must: be under age 65; have been for at least 30 days and remain legal residents of Texas; and be United States citizens or permanent legal residents of the United States for at least three continuous years.

f. Even if You meet an eligibility requirement above, You are not eligible for coverage by the Pool if one or more of the following applies:

1. You have other Health Benefit Plan coverage in effect on the date Pool coverage would otherwise be effective (does not apply to eligibility under the HCTC Program);

2. You are eligible for or covered by Group Health Plan, Church Plan or Government Plan coverage, including a self-insured health benefit plan or continuation of coverage under state or federal law, unless You qualify under one of the following exceptions:
   a) Your Group Health Plan, Church Plan or Governmental Plan coverage, continued under state or federal law, is maintained for the period of time necessary to satisfy any Preexisting Condition limitation period for Pool coverage or during any preexisting condition waiting period or other waiting period of the Group Health Plan, Church Plan or Governmental Plan coverage (does not apply to eligibility under the HCTC Program);
   b) Your Group Health Plan, Church Plan or Governmental Plan coverage either excludes an individual or limits coverage for an individual by conditional riders; a preexisting condition limitation does not constitute an exclusion or a conditional rider of an individual or an individual's medical condition (does not apply to eligibility under the HCTC Program);
   c) You are a part-time employee of an employer (You usually work less than 30 hours a week for the employer), the Group Health Plan, Church Plan or Governmental Plan offered by the employer is more limited or restricted than the Pool coverage, as determined by the Pool in its sole discretion, and the employer does not pay, directly or indirectly, any portion of the cost of Your coverage under the Group Health Plan, Church Plan or Governmental Plan (a copy of the coverage document for the employer's coverage and proof that the employer pays no portion of the cost, either directly or indirectly, will be required); or

d) You were eligible for continuation under federal law (Title X, Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) or a comparable federal or state employee coverage continuation program) or Texas law (Subchapter F or G, Chapter 1251, or Subchapter G, Chapter 1271, Texas Insurance Code), but You either did not elect continuation of coverage during the election period or Your elected continuation of coverage has lapsed or been cancelled without reinstatement, provided, however, that if You qualify under this section, You are subject to a Pool coverage exclusion of at least 180 days from the Pool coverage effective date for any Preexisting Condition, regardless of Your prior Creditable Coverage; provided, however, that You are not subject to the 180-day exclusion period if You continued coverage for the maximum period allowed under federal law, even if You did not elect further continuation under Texas law, at the expiration of the federal continuation period.

Note: If You or Your dependents were covered by a prior Group Health Plan, Church Plan or Governmental Plan, You and Your dependents may be eligible for federal or state continuation. If You were eligible for and were offered federal or state continuation, You may be eligible for Pool coverage pursuant to Section 3f, subsection 2d). A dependent, covered under the terminating prior Group Health Plan, Church Plan or Governmental Plan, is entitled to continuation, regardless of the continuation election of the employee.

3. You are covered by individual Health Benefit Plan coverage, unless You cancel or lapse such other coverage within 60 days after the effective date of Pool coverage. If such other individual Health Benefit Plan coverage limits coverage for an individual by excluding one or more medical conditions, such other coverage may be continued while the Pool coverage is in force. During any period other individual Health Benefit Plan coverage is in effect, after the effective date of Your Pool coverage, the Pool coverage will be secondary to such other coverage.

4. You have terminated coverage through the Pool within the twelve months preceding Your application for coverage by the Pool, unless You demonstrate a good faith reason for the termination (this item does not apply to persons eligible as Federally Defined Eligible Individuals).

5. You are confined to a county jail or imprisoned in a state or federal prison.

6. You have premiums paid or reimbursed by or under any government sponsored program or any government agency or health care provider (does not apply to eligibility under the HCTC Program).

7. You had prior coverage by the Pool that was terminated for nonpayment of premiums within the twelve months preceding Your application for coverage by the Pool.

8. You had prior coverage by the Pool that was terminated for fraud.

9. You have received $3,000,000 in benefits from the Pool under the Policy, including the benefits paid under any other Pool policies.

Additional Insured Person: You may apply to add a new eligible Insured Person to this Policy. Written application and payment of additional premium are required. The acceptance of such new Insured Person will be shown by amendment, to be attached to the Policy. The effective date of such amendment will be the effective date of coverage with respect to such new Insured Person.

SECTION 4. RENEWAL AGREEMENT AND TERMINATION

The Policy will be renewed each time the required premium payment is made on a timely basis, subject to You continuing to be eligible for coverage as provided in Section 3. The Pool will require each Insured Person to provide evidence of such continued eligibility.

Coverage will terminate for each person insured under this Policy:

1. 31 days after the day on which a premium payment for the Policy becomes due if payment is not made before that date;

2. The earlier of the premium due date or the first day of the month that follows the date on which the Pool determines:
   a. an Insured Person is no longer eligible for coverage under the Pool;
   b. an Insured Person is no longer a resident of the state of Texas, except for: a child who is a student under the age of 25 and financially dependent upon You; a child for whom You have received a court or administrative order to provide medical support, including Health Benefit Plan coverage; or a child of any age who is disabled and dependent on You; or

c. an Insured Person is 65 years old (does not apply to a Federally Defined Eligible Individual, if that person is not eligible for Medicare or to an Insured Person enrolled under the HCTC program, if that person is not enrolled in Medicare Part B);

3. 30 days after the date We make inquiry concerning an Insured Person's place of residence or any other eligibility criteria and You do not reply;

4. On the first day of the month that follows the date Your written request for termination of coverage is received;

5. On the date of the Insured Person's death; or

6. On the date state law requires cancellation of this Policy.

SECTION 5. PREEXISTING CONDITION LIMITATION

During the first 12 months following the effective date of coverage of an Insured Person, the Policy will not pay benefits for any charges or expenses for a Preexisting Condition, except as indicated below:

1. The Preexisting Condition limitation will not apply to an Insured Person who is a Federally Defined Eligible Individual, eligible pursuant to Section 3a.

2. The Preexisting Condition limitation will not apply to an Insured Person, eligible under the HCTC Program, who was continuously covered for an aggregate period of at least 3 months by Creditable Coverage that was in effect up to a date not more than 63 days before the Insured Person's effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy for the Insured Person is made no later than 63 days following the termination of such Creditable Coverage.

3. Except for an Insured Person who is eligible under Section 3f, subsection 2d) (qualification under the federal or state continuation exception), the Preexisting Condition limitation will not apply to an Insured Person who: a) was continuously covered for an aggregate period of at least 12 months by Creditable Coverage, including any waiting period, that did not end more than 63 days before the Insured Person's effective date under this Policy, provided that application for coverage under this Policy for the Insured Person is made no later than 63 days following the termination of such Creditable Coverage; or b) has been continuously covered, since birth, adoption or Your suit for adoption of the Insured Person, by Creditable Coverage, including any waiting period, that did not end more than 63 days before the Insured Person's effective date under this Policy, provided that application for coverage under this Policy for the Insured Person is made no later than 63 days following the termination of such Creditable Coverage. In determining whether the Preexisting Condition limitation applies to an Insured Person, credit will be given for the time the Insured Person was covered under any prior Creditable Coverage, including any waiting period for that coverage, that was in effect at any time during the 12 months before the Insured Person's effective date under this Policy.

4. An Insured Person, who is eligible under Section 3f, subsection 2d) (qualification under the federal or state continuation exception), will be subject to a 12-month Preexisting Condition limitation period. This limitation period will be reduced by the number of months, not to exceed 6 months, that the Insured Person was covered under any prior Creditable Coverage, including any waiting period for that coverage, in effect at any time during the 12 months before the Insured Person's effective date under this Policy.

SECTION 6. PREFERRED PROVIDER NETWORK (PPO)

a. **Blue Choice® Program Preferred Provider Network**
The three types of providers covered under this Policy are a Preferred (BlueChoice) Provider, a ParPlan Provider and a Non-Preferred (Non-BlueChoice, Non-Par) Provider. A **Preferred Provider** is a Hospital, Skilled Nursing Facility or any other medical or health related service facility or Physician that is a member of a Network selected for this Policy. A **Non-Preferred Provider** is a Hospital, Skilled Nursing Facility or any other medical or health related service facility or Physician that is not in the Network chosen by the Pool for this Policy. A **ParPlan Provider** is a Non-Preferred Provider that has agreed with the Administrator to: file Your claims; not bill You for the difference between the ParPlan Provider's charge and the Allowable Amount covered under this Policy for any treatment or services; and not bill You for treatment or services that are not Medically Necessary, as determined by the Administrator. Charges by a ParPlan Provider will be covered under this Policy as Non-Preferred Provider charges. See Section 8 for the definition of Allowable Amount.

When the Insured Person chooses a Preferred Provider, this Policy pays a greater Coinsurance Percentage as indicated in the Policy Schedule. If the Insured Person chooses a Non-Preferred Provider, including a ParPlan Provider, the Coinsurance Percentage payable by the Policy will be lower.

Covered Expenses for treatment or services provided by a Preferred Provider will be paid at the applicable Allowable Amount, subject to the Preferred Provider Coinsurance Percentage and the deductibles shown in the Policy Schedule. Covered Expenses for treatment or services provided by Non-Preferred Providers, including ParPlan Providers, will also be paid at the Allowable Amount for such treatment or services, subject to the deductibles and Non-Preferred Provider Coinsurance Percentage shown in the Policy Schedule.

A list of Preferred Providers in Your area is contained in the Preferred Provider Directory that was provided to You. You may call the Administrator to obtain the name of a Preferred Provider outside Your area, if needed. Any changes to the list of Preferred Providers will be made available to You not less than annually. You may call the Administrator during regular business hours to receive a current list of Preferred Providers. The list of Preferred Providers changes from time to time, so it is important for You to verify the network status of Your providers. You can do this by confirming with Your provider that the provider is a member of the Network or by calling the Administrator or checking the list of current Preferred Providers found on the Pool's web site (www.txhealthpool.org).

If an Insured Person's Preferred Provider's arrangement with the Network, chosen by the Pool for this Policy, terminates and, at the time of such termination, the Insured Person has special circumstances, benefits for Covered Expenses received from that provider will be paid as if the Covered Expenses were received from a Preferred Provider until: in the case of an Insured Person who has been diagnosed with a terminal illness, the end of nine months after the effective date of termination; in the case of an Insured Person who, at the time of termination, is past the 24th week of pregnancy, delivery of the child, immediate post-partum care and the follow-up checkup within the first six weeks after the delivery; or in all other special circumstances, the end of 90 days after the date of termination.

"Special circumstances" means a condition such that the treating Physician reasonably believes that discontinuing care by the treating Physician could cause harm to the patient. Special circumstances must be identified by the treating Physician who must: make a request to the Administrator that the Insured Person be permitted to continue treatment under the Physician's care; and agree not to seek payment from the Insured Person for any amounts in excess of the Preferred Provider rate for the treatment or services rendered.

When an Insured Person receives covered Emergency Care Services from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Insured Person can be safely transferred to a Preferred Provider, the Insured Person must be transferred to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Insured Person chooses not to transfer, Policy benefits will be payable at the lower Non-Preferred Provider level.

If there are no Preferred Providers available to the Insured Person, the Insured Person must contact the Administrator at the toll free number of the Administrator. Generally, Preferred Providers will be considered to be unavailable if an Insured Person resides more than 30 miles from a Preferred Provider. If there are no Preferred Providers available to the Insured Person, and the Insured Person receives approval from the Administrator before obtaining services from the Non-Preferred Provider, the Covered Expenses of that Insured Person for treatment or services by a Non-Preferred Provider will be paid at the Preferred Provider Coinsurance Percentage. If the Insured Person fails to obtain approval from the Administrator prior to obtaining the services of a Non-Preferred Provider, Covered Expenses for treatment or services by that Non-Preferred Provider will be paid at the Non-Preferred Provider Coinsurance Percentage, regardless of the availability to the Insured Person of a Preferred Provider.

IMPORTANT: All claim payments are based on Allowable Amounts. Preferred Providers, contracted with the Administrator, must accept these Allowable Amounts as payment in full, subject to the deductibles and Preferred Provider Coinsurance Percentage. If You use a Non-Preferred Provider, You will be responsible for charges over the Allowable Amount, in addition to the deductibles and Your share of the Non-Preferred Provider Coinsurance Percentage. ParPlan Providers have agreed to accept the Allowable Amount as payment in full, subject to Your payment of the deductibles and Your share of the Non-Preferred Provider Coinsurance Percentage.

Even if You consult a Preferred Provider, ask about any other providers rendering care to You. For example, if You are scheduled for surgery, ensure that Your Preferred Provider surgeon will be using a Preferred Provider facility for Your procedure and a Preferred Provider for Your anesthesia, radiology or pathology services.

Services You receive during an inpatient or outpatient admission may include care rendered by hospital-based, ancillary Non-Preferred Providers, such as an anesthesiologist, pathologist, radiologist, neonatologist or emergency medicine physician. To confirm if Your Preferred Provider facility includes ancillary Preferred Providers, go to "Provider Finder"

at http://www.bcbstx.com/onlinedirectory/ppo.htm and, in the Custom Search box, click on the link at the "Important Note" to verify information for Your facility.

b. **BlueCard Program**

The BlueCard Program provides access to Preferred Providers of other Blue Cross and/or Blue Shield Plans outside Texas. If an Insured Person incurs Covered Expenses in a location outside Texas through the BlueCard Program, the Insured Person must pay the Preferred Provider Coinsurance Amount, after payment of the deductibles and subject to the Preferred Provider Coinsurance Maximum. The amount of Covered Expenses for a BlueCard Provider will be calculated using the lesser of: the billed charges of the BlueCard Provider or the negotiated rate the Administrator pays the local Blue Cross and /or Blue Shield Plan.

The negotiated rate means: (1) the actual fee paid on the claim; or (2) an estimate of the fee to be charged by the provider under the BlueCard Program. An estimated fee may be prospectively adjusted to reflect the actual fee charged under the BlueCard Program.

SECTION 7. PREAUTHORIZATION, CASE MANAGEMENT AND CHRONIC CONDITION DISEASE MANAGEMENT

PREAUTHORIZATION: Preauthorization by the Utilization Reviewer is required for certain types of care and services. It is the responsibility of the Insured Person to preauthorize all services requiring preauthorization. Unless otherwise shown on the Policy Schedule, the Utilization Reviewer is the Administrator. In addition, certain benefits administered by the Pharmacy Manager are subject to Prior Authorization. Please see the Prescription Drug benefit for details.

Hospital Confinement: If an Insured Person is admitted to a Hospital or other facility as an inpatient, the confinement must be preauthorized.

Other Services Requiring Preauthorization: Preauthorization by the Utilization Reviewer is also required for other Covered Expenses listed below:

1. Home Health Care visits and services;
2. Home Infusion Therapy;
3. Hospice Care on an inpatient or outpatient basis;
4. Confinement in an extended care facility, including a Skilled Nursing Facility;
5. Rental or purchase of Durable Medical Equipment, for which the expected charge will exceed $2,000, except Durable Medical Equipment for treatment of diabetes; and
6. Organ and tissue transplants

The Utilization Reviewer will review the Medical Necessity of the care and services, specifying the approved level of care and, for inpatient confinements, certifying the number of inpatient days eligible for coverage. In making these determinations, the diagnosis, physical status and any other complicating conditions of the Insured Person will be taken into account. The Utilization Reviewer will review any x-ray and laboratory results and confer with the attending Physician if necessary. If an inpatient admission is deemed to be Medically Necessary, benefits will be available for up to the number of days certified. Benefits will be payable for Covered Expenses only to the extent that the Utilization Reviewer determines that the Covered Expenses are Medically Necessary.

If an Insured Person does not obtain preauthorization of services, the benefit for Covered Expenses will be reduced by 50%. If an Insured Person is admitted to a Hospital or receives other services as the result of an Emergency Injury or Emergency Illness, the preauthorization rules stated above apply. The request for certification must be made within forty-eight (48) hours of the admission or initiation of services or as soon as reasonably possible. If the Emergency admission or service occurs on a weekend or holiday, notification may be extended to the first business day following the Emergency admission or service. The request may be made by a phone call to the Utilization Reviewer by the Insured Person, the Insured Person's Physician, the Hospital or by a member of the Insured Person's Immediate Family. If the Insured Person is unconscious, in a coma or otherwise unable to contact the Utilization Reviewer due to Illness or Injury rendering the Insured Person physically or mentally incapable, the notification requirement will be waived until the Insured Person is able to contact the Utilization Reviewer. Certification will be retroactive to the date of admission or the initial dates of services for the Illness or Injury.

Preauthorization does not guarantee payments. All payments are subject to determination of the Insured Person's eligibility, payment of required deductibles, Copayments and Coinsurance amounts, eligibility of charges as Covered Expenses, and application of the Exclusions and Limitations and other provisions of this Policy at the time the services are rendered.

CONTINUED STAY REVIEW: Benefits will only be available for the number of days certified. If the confinement will last longer than the number of days certified, the Utilization Reviewer must be notified. The Utilization Reviewer will then conduct a continued

stay review. The Utilization Reviewer will review the case with the attending Physician to determine the Medical Necessity of any additional inpatient days. Benefits will not be available for any days beyond those certified.

CASE MANAGEMENT: The Case Manager will assess the continuing care needs in catastrophic and chronic high cost medical care cases and discuss with the attending Physician more efficient alternative means of medical care. Unless otherwise shown on the Policy Schedule, the Case Manager is the Administrator. Coverage may be provided for more efficient alternatives, even though such alternatives are not specifically stated in this Policy. Coverage for alternative care is subject to the same overall Lifetime Maximum, deductibles, Copayment and/or Coinsurance requirements that apply to the medical care being replaced. As a condition of coverage by the Pool, the Insured Person must cooperate with the involvement of the Case Manager. A Case Manager may contact the Insured Person and the treating Physician whenever the Insured Person is admitted to a Hospital or other facility as an inpatient or whenever the treating Physician makes a request for certain courses of treatment. If the Insured Person refuses to fully cooperate with and allow the participation of the Case Manager in his or her care or treatment, services may not be covered by the Pool.

CHRONIC CONDITION DISEASE MANAGEMENT: The Pool provides certain chronic condition disease management programs. If an Insured Person has a diagnosis of or is being treated for a condition for which a chronic condition disease management program is provided, the Insured Person will be contacted to participate in the program. Participation in the chronic condition disease management program is mandatory. If an Insured Person refuses to participate, a written notice will be sent to the Insured Person's last known address, notifying the person that unless and until he or she becomes a participant in and compliant with the applicable program, Pool coverage may not be provided for services and treatment associated with that particular condition. The Pool will continue to provide benefits for covered services for other conditions.

SECTION 8. BENEFITS PROVISIONS

Once an Insured Person's deductibles are satisfied, the Policy will pay the amount of Covered Expenses in excess of the applicable Coinsurance amount. Once You have paid Your Coinsurance Maximum for a calendar year, the Policy will pay 100% of Covered Expenses for the remainder of that calendar year. In no event will the Policy pay more than the Lifetime Maximum for each Insured Person.

Allowable Amount is the maximum amount that will be allowed by the Pool for a covered medical service, supply or procedure. For a Preferred Provider, the Allowable Amount is based on the terms of the Preferred Provider network contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRGs), fee schedules, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

For Non-Preferred Providers, the Allowable Amount will be the lesser of the Non-Preferred Provider's billed charges or the Preferred Provider Organization's (PPO) Non-Preferred Provider Allowable Amount. The Non-Preferred Provider Allowable Amount is developed using the PPO's network Allowable Amount data for similar Preferred Providers at a service level identified by standard contracting identification methods. The Allowable Amount for Non-Preferred Providers represents the average contract rate for Preferred Providers adjusted by a predetermined factor established by the PPO and updated on a periodic basis. Such factor shall not be less than 75% and will be updated not less frequently than once every two years. The Non-Preferred Provider Allowable Amount does not equate to the Non-Preferred Provider's billed charges and Insured Persons receiving services from a Non-Preferred Provider will be responsible for the difference between the Non-Preferred Allowable Amount and the Non-Preferred Provider's billed charges, and this difference may be considerable. To find out the PPO Non-Preferred Provider Allowable Amount for a particular service, Insured Persons may call customer service at the number shown on the identification card.

For multiple surgeries, the Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus a determined percentage of the Allowable Amount for each of the other covered procedures performed.

For procedures, services, or supplies provided to Medicare recipients, the Allowable Amount will not exceed Medicare's limiting charge.

When the Administrator has an insufficient data base (charge detail of less than three 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 Administrator shall determine an Allowable Amount for a service or supply by "manual pricing," in accordance with the Administrator's manual pricing methodology.

IMPORTANT: All claim payments are based on Allowable Amounts. Preferred Providers, contracted with the Administrator, must accept these Allowable Amounts as payment in full, subject to the deductibles and Preferred Provider Coinsurance Percentage. If You use a Non-Preferred Provider, You will be responsible for charges over the Allowable Amount, in addition to the deductibles and Your share of the Non-Preferred Provider Coinsurance Percentage. ParPlan

Providers have agreed to accept the Allowable Amount as payment in full, subject to Your payment of the deductibles and Your share of the Non-Preferred Provider Coinsurance Percentage.

Even if You consult a Preferred Provider, ask about any other providers rendering care to You. For example, if You are scheduled for surgery, ensure that Your Preferred Provider surgeon will be using a Preferred Provider facility for Your procedure and a Preferred Provider for Your anesthesia, radiology or pathology services.

Services You receive during an inpatient or outpatient admission may include care rendered by hospital-based, ancillary Non-Preferred Providers, such as an anesthesiologist, pathologist, radiologist, neonatologist or emergency medicine physician. To confirm if Your Preferred Provider facility includes ancillary Preferred Providers, go to "Provider Finder" at http://www.bcbstx.com/onlinedirectory/ppo.htm and, in the Custom Search box, click on the link at the "Important Note" to verify information for Your facility.

Calendar Year Deductible means the amount of Covered Expenses for each Insured Person You must pay each calendar year before benefits are available. The Calendar Year Deductible is shown in the Policy Schedule. The Calendar Year Deductible amount selected may not be changed to a lower amount after the Policy is issued. You may request to change to a higher Calendar Year Deductible, if offered by the Pool, but only one such change will be allowed in a calendar year. The change will be effective on the first of the month following the date the Pool receives Your written request for such change or on a later date, if You request it. Covered Expenses are applied toward the Calendar Year Deductible in the calendar year in which they are incurred.

Coinsurance means the amount You must pay for Covered Expenses for each Insured Person under the Policy, after You meet the deductibles. The Coinsurance Amounts are shown in the Policy Schedule. Coinsurance does not include charges for services that are not covered under the Policy or charges that are applied to meet the Calendar Year Deductible, the Emergency Care Deductible or the Physician Office Visit Copayments, or charges for outpatient prescription drugs, including charges applied to the Prescription Drug Deductible or Copayments,.

The **Coinsurance Maximum** amounts for Covered Expenses for an Insured Person are shown in the Policy Schedule. After You pay the applicable maximum for an Insured Person in each Policy Year, We will pay 100% of Covered Expenses for the remainder of that calendar year. The Coinsurance Maximums do not include the Calendar Year Deductible, the Emergency Care Deductible, the Physician Office Visit Copayments or charges for outpatient prescription drugs, including charges applied to the Prescription Drug Deductible or Copayments.

Lifetime Maximum or Lifetime Maximum Amount is the maximum amount of Covered Expenses payable by the Pool under this Policy and any other Pool policy for each Insured Person. The Lifetime Maximum Amount is $3,000,000. Benefits paid under the Developmental Delay benefit of this Policy (Covered Expenses, item 20) do not apply to the Lifetime Maximum Amount.

Covered Expenses are charges incurred by an Insured Person for services and supplies that are: not in excess of the Allowable Amount for the treatment, service or supply; determined by the Administrator to be Medically Necessary for the diagnosis or treatment of an Illness or Injury; and listed below.

Covered Expenses are:

1. Physician Charges
   a. Physician Office Visit: Physician services during a visit to a Physician's office, Retail Health (Walk-In) Clinic or Urgent Care Clinic, limited to the: examination or gathering information on an Illness or Injury; or providing a diagnosis and plan of treatment for an Illness or Injury. The Office Visit benefit covers only the Physician's charge for the examination itself; it does not cover: preventive care or other services for Illness or Injury, including x-ray or lab services, even if performed in the Physician's office. Retail Health (Walk-In) Clinic or Urgent Care Clinic and/or on the same day. See the Policy Schedule for the applicable Copay or Coinsurance amounts.
   b. All other services by a Physician for diagnosis, treatment, and surgery for an Illness or Injury, including administration of covered injectable prescription drugs such as injectable drugs for treatment of allergies, in the Physician's office, unless provided through the Pharmacy Manager. Inpatient Hospital or Ambulatory Surgical Center visits are limited to one visit for each Physician per day.
   c. Assistant surgery fee for one assistant when the procedure requires an assistant surgeon or Surgical First Assistant due to medical necessity, not to exceed 25% of the primary surgeon's fee. **Surgical First Assistant** means a licensed practitioner (Physician's assistant or registered nurse), practicing in accordance with the Standards of the Texas Board of Medical Examiners and/or Texas Board of Nursing Examiners and meeting the Hospital's credentialing criteria for a first assistant.
   d. Second Surgical Opinion, if requested by the Pool.
   e. Outpatient therapy provided by a licensed practitioner, including physical therapy performed by a qualified licensed physical therapist, occupational therapy performed by a qualified licensed occupational therapist or speech-language therapy performed by a qualified licensed speech language therapist, limited to a combined maximum benefit of $5,000 per calendar year.

Physical and/or occupational therapy includes spinal manipulation, manual or electrical muscle stimulation and other manipulative or ultrasound therapy for vertebrae, disc, spine, back and neck. The calendar year maximum benefit does not apply to treatment of acquired brain injury or Serious Mental Illness.

2. Hospital
   a. Inpatient
      1) Daily Hospital room, board and general nursing services, not to exceed the average daily semi-private room rate. If a Hospital does not have an established semi-private room rate, 80% of the charges for the private room will be considered a Covered Expense, unless the Hospital is a Preferred Provider that has agreed to accept a different Allowable Amount. Coverage will be provided for a minimum inpatient stay of 48 hours following a covered mastectomy and for a minimum inpatient stay of 24 hours following a covered lymph node dissection for the treatment of breast cancer.
      2) Confinement in an Intensive Care or cardiac care unit, not to exceed a maximum of three times the average semi-private room rate.
      3) Miscellaneous Hospital-billed services and supplies, including but not limited to: operating room; recovery room; surgical dressings; casts; splints; trusses; braces; initial artificial limbs or eyes; blood, when not replaced, and its administration; and drugs and medicines administered while Hospital confined.

   b. Outpatient
      1) Outpatient services provided by a Hospital or other emergency facility for Emergency Care, subject to an Emergency Care Deductible per visit, shown in the Policy Schedule, in addition to the Calendar Year Deductible. The Emergency Care Deductible will be waived if the Emergency Care visit results in an inpatient admission to the Hospital immediately following the Emergency Care visit.
      2) Surgical services and supplies, provided by a Hospital outpatient facility or an Ambulatory Surgical Center, on the day surgery is performed.
      3) Preadmission Testing, done on an outpatient basis only, within seven days prior to a planned Hospital admission.

   c. Definitions

      1) **Ambulatory Surgical Center** means a licensed public or private establishment with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures with continuous Physician services and registered professional nursing services when a patient is in the facility and that does not provide services or accommodations for patients to stay overnight. It does not include a Hospital emergency department, trauma center, Physician's office or center for termination of pregnancy.

      2) **Hospital** means:
         a) a facility that:
            i) is licensed as a hospital and operated pursuant to law;
            ii) is primarily engaged in providing or operating either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians, medical diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made;
            iii) provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.);
            iv) maintains and operates a minimum of five beds;
            v) has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis;
            vi) maintains permanent medical history records; or
         b) a facility that is accredited by the Joint Commission on Accreditation of Health Care Organization.

         The major surgery facility requirement is hereby waived for facilities that specialize in treating the mentally ill. Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, whether such facilities are operated as a separate institution or as a section of an institution operated as a hospital. Hospital does not mean a facility primarily providing custodial care or educational services.

      3) **Hospital Confinement** means confinement as a bed patient within a Hospital, as defined herein, for a period not less than twenty-four (24) hours under the care and attendance of a licensed Physician or surgeon.

      4) **Intensive Care or Intensive Care Unit** includes a cardiac care unit and means a section, ward or wing within the Hospital that is separated from other Hospital facilities and:
         a) is operated exclusively for the purpose of providing care and treatment of critically ill or injured patients; and
         b) has special supplies and equipment necessary for such care and treatment of critically ill or injured patients; and

c) provides room and board and close observation and care by registered nurses and other specially trained hospital personnel; excluding any Hospital facility maintained for the purpose of providing normal postoperative recovery treatment or service.

3. Preventive Care

Services for the following preventive care benefits:

a. Well child care for an Insured Person for the following services:
   1) Ophthalmologic examination for infants at risk for eye problems.
   2) The following immunizations, from birth through 6 years of age: a test for tuberculosis, immunization and reimmunization against diphtheria, pertussis, tetanus, poliomyelitis, Haemophilus influenzae type b, measles, mumps, rubella, varicella, hepatitis B and any other immunization that is required by law for a child. This benefit is not subject to the Calendar Year Deductible or coinsurance.
   3) A screening test for hearing loss for an Insured Person from birth through the date the Insured Person is 30 days old and follow-up care to the screening test for the Insured Person from birth until the date the Insured Person is 24 months old. This benefit is not subject to the Calendar Year Deductible.

b. Other Preventive Care benefits:
   1) Diagnostic examination for early detection of cervical cancer, including the provider's charge for administration of the test, for any insured female age 18 or older, not to exceed one per calendar year for: a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of the human papillomavirus. A screening test must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the Insurance Commissioner. Covered Expenses from a Preferred Provider are not subject to the Calendar Year Deductible.
   2) Screening by low dose mammography for any insured female age 35 or over, with a family history of or another risk factor for breast cancer, or a female age 40 or older, not to exceed one per calendar year. Low-dose mammography means the X-ray examination of the breast using equipment dedicated specifically for mammography including the X-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid breast, with two views for each breast. Covered Expenses from a Preferred Provider are not subject to the Calendar Year Deductible.
   3) Screening for detection of prostate cancer per calendar year: one physical examination for the detection of prostate cancer; and one prostate - specific antigen test for an insured male at least 50 years of age and asymptomatic or an insured male at least 40 years of age with a family history of or another risk factor for prostate cancer. Covered Expenses from a Preferred Provider are not subject to the Calendar Year Deductible.
   4) Screening for detection of colorectal cancer: for an Insured Person at least 50 years of age and at normal risk for developing colon cancer:
      a. an annual fecal occult blood test and a flexible sigmoidoscopy once every five years; or
      b. a colonoscopy once every ten years.

      Covered Expenses from a Preferred Provider are not subject to the Calendar Year Deductible.
   5) Screening for detection of cardiovascular disease: for an insured male older than 45 years of age or a female older than 55 years of age, who is diabetic or has a risk of developing coronary heart disease, based on a score that is intermediate or higher, derived using the Framington Heart Study coronary prediction algorithm, once every five years, coverage of up to $200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function, performed by a laboratory certified by a national organization:
      a. computed tomography (CT) scanning measuring coronary artery calcification; or
      b. ultrasonography measuring carotid intima-media thickness and plaque.
   6) Immunizations for influenza and pneumonia.

c. Outpatient contraceptive services: Charges for a consultation, examination, procedure or medical service, provided on an outpatient basis and related to the use of a prescription drug or device to prevent pregnancy. Charges for contraceptive drugs or devices, approved by the United States Food and Drug Administration are covered, unless covered under the Prescription Drug benefit.

d. Other preventive care services, including routine physical examinations, well-child care, routine lab and x-ray charges, immunizations, other than influenza and pneumonia (see b) 6) above), for Insured Persons over age 6 and well care consultations, such as a colonoscopy referral. Benefits are subject to the applicable Coinsurance amount, but are not subject to the Calendar Year Deductible when services are provided by a Preferred Provider. Benefits are limited to a combined Calendar Year maximum benefit of $300 for PPO and Non-PPO charges.

4. Skilled Nursing Facility

Room, board, and other services in a Skilled Nursing Facility, not to exceed 45 days per calendar year, provided that the confinement is certified by a Physician as necessary for recovery from an Illness or Injury and is in lieu of Hospital Confinement. Confinement in a Skilled Nursing Facility for treatment of diabetes does not have to be in lieu of hospitalization.

Skilled Nursing Facility means a facility that is operated pursuant to law and is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician. It must provide continuous, 24-hour-a-day nursing service by or under the supervision of a registered nurse (RN) and maintain a daily medical record of each patient. A Skilled Nursing Facility includes a rehabilitation facility, but does not include any home, facility or part thereof used primarily for rest, care and treatment for the aged, drug dependency, alcohol abuse, tuberculosis, mental disease or disorders or custodial or educational care.

5. Home Health Care

Home Health Care Services under a Plan of Care, if certified by the attending Physician that hospitalization or confinement in a Skilled Nursing Facility would otherwise be required. Covered Home Health Care Services are limited to a maximum benefit of the lesser of 60 visits or $5,000 per calendar year. A visit by a nurse or therapist will be considered one visit. Each two hour period or portion thereof of home health aide service is considered one visit.

Services include:

a. Skilled nursing by a registered nurse, under the supervision of a Physician, or by a licensed vocational nurse, under the supervision of a registered nurse and a Physician;
b. Physical, occupational, speech or respiratory therapy;
c. Service of a home health aide under the supervision of a registered nurse; and
d. The furnishing of medical equipment and medical supplies.

In addition to the limitations otherwise listed in this Policy, Covered Expenses for Home Health Care Services will not include charges for:

a. Services or supplies not included in the Plan of Care;
b. Services of any person who normally lives in Your home or is an Immediate Family Member of the Insured Person;
c. Custodial care; or
d. Transportation services.

Home Health Care means the provision of health services through a home health agency (a business that provides home health service and is licensed by the Texas Department of Health under Chapter 142, Health and Safety Code) in an Insured Person's residence under a Plan of Care.

Custodial Care means services or supplies that: are furnished mainly to train or assist in personal hygiene or activities of daily living (bathing, dressing, assistance with mobility, feeding or taking oral medications), rather than to provide therapeutic treatment; can safely and adequately be provided by persons who do not have the technical skills of a Physician; are requested by or for the convenience of the Insured Person or the Insured Person's family; or enable Immediate Family Members of the patient to work outside the home. Such care is custodial, regardless of who recommends, provides or directs care, where the care is provided, or whether or not the Insured Person can be or is being trained for self-care.

Plan of Care means a written individualized plan of services, established by a Physician of Your choice, that fairly, accurately and appropriately addresses the Insured Person's care needs. The Plan of Care must be certified by the Physician as necessary for medical purposes and must be reviewed every two months by the attending Physician. The Plan of Care must include: diagnosis, symptoms, complaints and complications; reasons for admission or services and reason for continued care; Physician's orders; schedule of treatment, including the duration, frequency, type and scope of services necessary for care; physical limitations or impairments; and objectives of the Plan of Care. Before We authorize payment of benefits for Covered Expenses requiring a Plan of Care, We must be sent a copy of the Insured Person's Plan of Care upon its completion and updating, as required.

6. Home Infusion Therapy

Home infusion therapy performed by a provider licensed by the state to provide home infusion therapy, including prescription supplements for parenteral/enteral feeding therapy.

7. Hospice Care

Hospice Care provided by a licensed Hospice Care Facility for any Insured Person who, in the opinion of the attending Physician, has no reasonable prospect of cure and is expected to live no longer than six months, not to exceed a lifetime maximum benefit of the lesser of 180 days or $10,000.

Hospice Care means a coordinated, interdisciplinary hospice provided program for meeting the physical, psychological, spiritual and social needs of dying individuals and their immediate families. Further, Hospice Care provides palliative and supportive medical, nursing and other health services through home and inpatient care during the Illness to individuals who have no reasonable prospect of cure and have a Physician-estimated life expectancy of less than six (6) months and bereavement care to the immediate families of those individuals.

Hospice Care Facility means a facility whose primary purpose is to provide to terminally ill persons medical and support services for symptom management and pain relief and that is licensed and operated according to the laws of the state in which it is located.

8. Miscellaneous Services

a. Anesthesia and its administration, in connection with a covered surgical procedure.

b. If for Emergency Care, professional ground or air ambulance services by an appropriately licensed provider for an Insured Person's transportation to the nearest Hospital equipped to treat the Injury or Illness or from a first treating facility to a second treating facility, not to exceed a calendar year maximum benefit of $2,000 for ground ambulance and a calendar year maximum benefit of $5,000 for air ambulance.

c. Oxygen and the rental of equipment for its administration.

d. The rental or purchase, at Our option, of Durable Medical Equipment, corrective appliances, orthotics and prosthetic devices required for therapeutic use, including repairs and necessary maintenance of such purchased devices, not otherwise provided for under a manufacturer's warranty or purchase agreement. If the equipment is purchased, We may require the return of the equipment to Us when it is no longer in use or if the Insured Person's coverage with Us is terminated within six (6) months of the date of such purchase.

Durable Medical Equipment means items that are able to withstand repeated use, customarily serve a medical purpose, generally are not useful in the absence of Illness or Injury and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, respirators, oxygen tents, dialysis machines, corrective appliances and adaptive equipment.

Orthotic Device means a mechanical device designed to support or supplement weakened joints or limbs.

Prosthetic Device means an artificial replacement of all or part of a body organ or limb, or other body part.

e. Radiation therapy, inhalation therapy, and chemotherapy, on an inpatient and outpatient basis.

f. X-ray and laboratory services, including imaging services, pathology, radiology, and the interpretation thereof, on an inpatient and outpatient basis.

g. Vasectomy and tubal ligation or occlusion.

h. Dietary formulas for treatment of Phenylketonuria (PKU) or other heritable diseases.

Heritable Disease means an inherited disease that may result in mental or physical retardation.

Phenylketonuria (PKU) means an inherited condition that may cause severe mental retardation if not treated.

i. Charges for amino acid-based elemental formulas, including Medically Necessary services for administration of the formula, regardless of the formula delivery method, when the treating physician has issued a written order stating that the formula is Medically Necessary for the diagnosis and treatment of:
   i) immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
   ii) severe food protein-induced enterocolitis syndrome;
   iii) eosinophilic disorders, as evidenced by the results of a biopsy; and
   iv) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

j. Charges by a Physician for telemedicine medical services or telehealth services.

Telehealth Service means a health care service, other than a telemedicine medical service, delivered by a licensed or certified health professional, acting within the health professional's license or certification, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including: (a) compressed digital interactive video, audio or data transmission; (b) clinical data transmission using computer imaging by way of still-image capture and store and forward; and (c) other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Service means a health care service, initiated by a Physician or provided by a health professional acting under Physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or

consultation by a Physician, treatment or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including: (a) compressed digital interactive video, audio or data transmission; (b) clinical data transmission using computer imaging by way of still-image capture; and (c) other technology that facilitates access to health care services or medial specialty expertise.

9. Routine Patient Care Costs for Participation in Clinical Trial
   Charges for any Medically Necessary services, for which benefits are provided by the Policy, when an Insured Person is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, provided:
   a. the clinical trial is approved by:
      1) the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
      2) the National Institute of Health;
      3) the U.S. Food and Drug Administration;
      4) the U.S. Department of Defense;
      5) the U.S. Department of Veterans Affairs; or
      6) an institutional review board of an institution in Texas that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
   b. the research institution, conducting the clinical trial, and each health professional, providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Amount, as payment in full for routine patient care provided in connection with the clinical trial.

   Coverage will not be provided for:
   a. the cost of an investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
   b. the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
   c. the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
   d. a cost associated with managing a clinical trial;
   e. the cost of a health care service that is specifically excluded by the Policy; or
   f. services that are part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

10. Transplant
    Charges related to transplants, including preparation and transportation, limited to the following transplants: kidney, pancreas, heart, liver, lung and bone marrow, subject to a lifetime combined maximum benefit for all such transplants of $300,000. Charges related to transplants will also include charges for a live donor, to the extent that benefits remain and are available under this benefit after the Eligible Charges for the Insured Person have been paid. In this regard, this Policy will be primary; other existing coverage of the donor will be secondary to the benefits available to the donor under this Policy.

    Services subject to the transplant lifetime benefit maximum include:
    a. Physician office visits, x-rays, laboratory tests, stress testing and other general physical evaluation before the transplant;
    b. Chemotherapy, radiation therapy related to the transplant;
    c. The evaluation of organs including, but not limited to, the determination of tissue matches;
    d. The removal of organs from deceased donors;
    e. The transportation and storage of donated organs;
    f. Prescription drugs used while hospital confined; and
    g. Complications arising from the transplant, for which hospitalization or another transplant is required.

    No benefits are available for an Insured Person or a donor for the following expenses:
    a. Living and/or travel expenses of the live donor or recipient;
    b. Donor search and acceptability testing of potential living donors; and
    c. Expenses related to maintenance of life for purposes of organ donation.

11. Diabetes
    Care and treatment of diabetes for an Insured Person who has been diagnosed with: insulin dependent or non-insulin dependent diabetes; elevated blood glucose levels induced by pregnancy; or another medical condition associated with elevated blood glucose levels for the following services and supplies:
    a. Diabetes equipment and supplies as follows (see Prescription Drug benefit for other covered supplies and equipment):
       1) Injection aids, including devices used to assist with insulin injection and needleless systems;
       2) Biohazard disposal containers;

3) Insulin pumps, both external and implantable, and associated appurtenances, that include: insulin infusion sets and devices; insulin pump batteries and cartridges; adhesive and other required disposable supplies for insulin pumps; and durable and disposable devices to assist in the injection of insulin;
4) Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
5) Podiatric appliances, including up to two pair of therapeutic footwear per year, for the prevention of complications associated with diabetes;
6) Other treatment and monitoring equipment, approved by the United States Food and Drug Administration (FDA), if Medically Necessary and deemed appropriate by the treating Physician through a written order; and
7) Unless covered by the Prescription Drug benefit, the following diabetes equipment and supplies:
   a) Blood glucose monitors, including noninvasive glucose monitors and monitors for use by or adapted for the legally blind;
   b) Test strips for use with a corresponding glucose monitor;
   c) Visual reading strips and urine testing strips and tablets that test for glucose, ketones and protein;
   d) Medications available without a prescription for controlling the blood sugar level.

b. Diabetes self-management training for which a Practitioner has written an order for the Insured Person or for the Caretaker of an Insured Person as follows: 1) a diabetes self-management training program recognized by the American Diabetes Association; 2) diabetes self-management training given by a multidisciplinary team, the non-doctor members of which are coordinated by a Certified Diabetes Educator, who is certified by the National Certification Board for Diabetes Educators, or a person who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and includes a combination of diabetes-related educational principles and behavioral strategies; such team consisting of at least a dietician and nurse educator and possibly including a pharmacist or a social worker; provided that all team members, except a social worker, must have recent didactic and experiential preparation in diabetes clinical and educational issues, as determined by the team member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training; 3) a Certified Diabetes Educator, certified by the National Certification Board for Diabetes Educators; or 4) diabetes self-management training in which one or more of the following components are provided: the nutrition counseling component provided by a licensed dietician, for which the dietician shall be paid; the pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid; any component of training provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except for providing a nutrition counseling or pharmaceutical component unless a licensed dietician or pharmacist is unavailable to provide that component; or any component of the training provided by a doctor of medicine; provided that a person may not provide a component of diabetes self-management training unless the subject matter of the component is within the scope of the person's practice and the person meets the education requirements, as determined by the person's licensing agency, in consultation with the commissioner of public health.

For purposes of the diabetes benefit only, a **Practitioner** means a doctor of medicine, advance practice nurse, doctor of dentistry, physician assistant, doctor of podiatry or other licensed person with prescriptive authority.

For the purposes of the self-management training, a **Caretaker** means a family member or significant other of the Insured Person who is responsible for ensuring that an Insured Person, who is not able to manage his or her diabetes, due to age or infirmity, is properly managed, including oversight of diet, administration of medications and use of equipment and supplies.

Self-management training includes: 1) the development of an individualized management plan created for and in collaboration with the Insured Person; and 2) medical nutritional counseling and instructions on the proper use of diabetes equipment and supplies.

Self-management training will be provided to the Insured Person or to a Caretaker for the Insured Person upon: 1) the initial diagnosis of diabetes; 2) a written order of a Practitioner indicating that a significant change in the Insured Person's symptoms or condition requires changes in the Insured Person's regime; or 3) a written order of a Practitioner that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.

12. Complications of Pregnancy
Complications of Pregnancy will be covered as any Illness, provided the pregnancy is not subject to the Pre-Existing Condition limitation of this Policy. **No benefits are available for other pregnancy and maternity care, including but not limited to normal deliveries, elective caesarean sections and elective abortions, except as provided in item 13 below.**

Complications of Pregnancy are conditions, requiring Hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from the pregnancy, but that are adversely affected by the pregnancy, including, but not limited to acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. **Complications of Pregnancy** also include non-elective caesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible. **Complications of Pregnancy** do not include elective abortion, elective caesarean section, false labor, occasional spotting, morning sickness, Physician prescribed rest during the period of pregnancy, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

13. Pregnancy of an Insured Person who is a Federally Defined Eligible Individual, pursuant to Section 3a
Benefits will be provided for the preexisting pregnancy of a Federally Defined Eligible Individual. Normal pregnancy and elective caesarian section will be covered as any illness if the pregnancy exists on the effective date of Pool coverage. No benefits will be provided for subsequent pregnancies, except as provided for Complications of Pregnancy in item 12 above.

14. Mastectomy
Charges for the following services and supplies for breast reconstruction in connection with a mastectomy:
    a. Reconstruction of the breast on which the mastectomy is performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
    c. Prostheses and services and other supplies necessary for any physical complication, including lymphedemas, at all stages of the mastectomy.

15. Reduction Mammoplasty
Reduction mammoplasty for symptomatic breast hypertrophy or hypermastia.

16. Reconstructive Surgery
Reconstructive Surgery only:
    a. Due to Accidental Injury or following a surgery that would be covered by the Policy; or
    b. To repair a congenital defect, disorder or anomaly, except a craniofacial abnormality, for an insured person under 19 years of age.

Reconstructive Surgery is surgery to correct the appearance of abnormal features or characteristics of the body caused by birth defects, disorders or anomalies or Injury, tumor or infection. A feature or characteristic of the body is abnormal when it creates a functional impairment or a reasonable person would consider it to be outside the range of general variations of normal human appearance.

17. Reconstructive Surgery for Craniofacial Abnormalities for an Insured Person under 19 years of age. **Reconstructive Surgery for Craniofacial Abnormalities** means surgery to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease.

18. Acquired Brain Injury
The following services, required for and related to an acquired brain injury:
    a. Cognitive rehabilitation therapy;
    b. Cognitive communication therapy;
    c. Neurocognitive therapy and rehabilitation;
    d. Neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing and treatment;
    e. Neurofeedback therapy;
    f. Remediation;
    g. Post-acute transition services;
    h. Community reintegration services, including outpatient day treatment services;
    i. Other post-acute treatment services; and
    j. Reasonable expenses for periodic reevaluation of the care of an Insured Person who: has an acquired brain injury; has been unresponsive to treatment; and becomes responsive to treatment at a later date. A determination of reasonable expenses may include consideration of: cost; the time expired since the last evaluation; any difference in the expertise of the health care practitioner performing the evaluation; changes in technology; and advances in medicine .

Coverage will not be denied based solely on the fact that treatment or services are provided at a facility other than hospital. Treatment may be provided at a facility at which appropriate services may be provided, including: a hospital regulated under Chapter 241, Health and Safety Code, including an acute or post-acute rehabilitation hospital; or an assisted living facility regulated under Chapter 247, Health and Safety Code.

Definitions:

Acquired brain injury means a neurological insult to the brain, that is not hereditary, congenital or degenerative. The injury to the brain occurred after birth and results in a change in neuronal activity, that results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

Cognitive communication therapy means services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.

Cognitive rehabilitation therapy means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services means services that facilitate the continuum of care as an affected individual transitions into the community.

Neurobehavioral testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family and others.

Neurobehavioral treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters and that are designed to result in improved mental performance and behavior and stabilized mood.

Neurophysiological testing means an evaluation of the functions of the nervous system.

Neurophysiological treatment means interventions that focus on the functions of the nervous system.

Neuropsychological testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Post-acute care treatment services means advanced rehabilitation services provided through an interdisciplinary team approach. Services are based on an assessment of the individual's cognitive deficits, with a treatment goal of achieving functional changes in a patient with brain injury by reinforcing, strengthening or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms. Services include cognitive rehabilitation services, behavior management and the development of coping skills and compensatory strategies.

Post-acute transition services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation means the process or processes of restoring or improving a specific function.

Services means the work of testing, treatment and providing therapies to an individual with an acquired brain injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

19. Serious Mental Illness

Inpatient and outpatient treatment for Serious Mental Illness, subject to a calendar year maximum benefit of 30 inpatient days and 50 outpatient visits, including charges for generally recognized services for treatment of autism spectrum disorder, prescribed by the Insured Person's primary care physician in the treatment plan recommended by that physician.

Inpatient charges will include psychiatric day treatment under the direction and continued medical supervision of a doctor of medicine or a doctor of osteopathy in a Psychiatric Day Treatment Facility that provides organizational structure and individualized treatment plans separate from an inpatient program. Any benefits provided will be determined as if care and treatment in a Psychiatric Day Treatment Facility was provided in a Hospital, except that two full days of treatment in a Psychiatric Day Treatment Facility shall be considered equal to one day of treatment in a Hospital for purposes of determining the benefit maximum. An attending doctor of medicine or osteopathy must certify that such treatment is in lieu of hospitalization.

Inpatient charges will also include treatment for Serious Mental Illness in a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents, provided confinement in a Hospital would otherwise be necessary. Each two days of treatment in a Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents will be considered equal to one day of treatment in a Hospital.

Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome or Pervasive Developmental Disorder—Not Otherwise Specified.

Crisis Stabilization Unit means a 24-hour residential program, appropriately licensed or certified as a Crisis Stabilization Unit or Facility, that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Generally Recognized Services for treatment of autism spectrum disorder may include such services as: evaluation and assessment services; applied behavior analysis; behavior training and behavior management; speech therapy; occupational therapy; physical therapy; or medications or nutritional supplements used to address symptoms of autism spectrum disorder, if provided by a health care practitioner: who is licensed, certified or registered by an appropriate agency of Texas; whose professional credential is recognized and accepted by an appropriate agency of the United States; or who is certified as a provider under the TRICARE military health system.

Neurobiological Disorder means an illness of the nervous system caused by genetic, metabolic or other biological factors.

Psychiatric Day Treatment Facility means a mental health facility that provides treatment of individuals suffering from Serious Mental Illness in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program and that is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Residential Treatment Center for Children and Adolescents means a child-care institution that provides residential care and treatment for Serious Mental Illness of children and adolescents and that is accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Serious Mental Illness means only the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): bipolar disorders (hypomanic, manic, depressive and mixed); depression in childhood and adolescence; major depressive disorders (single episode or recurrent); obsessive compulsive disorders; paranoid and other psychotic disorders; schizo-affective disorders (bipolar or depressive); schizophrenia; and autism spectrum disorder for an Insured Person, under age 10, from the date of diagnosis until the Insured Person's tenth birthday.

20. Developmental Delay

Charges for the following rehabilitative and habilitative therapies provided to an Insured Person under age 3 with a developmental delay, in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention, under Chapter 73 of the Texas Human Resources Code:

a. Occupational therapy evaluations and services;
b. Physical therapy evaluations and services;
c. Speech therapy evaluations and services; and
d. Dietary or nutritional evaluations.

Services must be provided in the amount, duration, scope and service setting established in the Insured Person's individualized family service plan. Benefits provided for such services are not subject to the Lifetime Maximum amount of this Policy.

21. Growth Hormone Treatment
    Growth hormone treatment provided by a Physician for: growth hormone deficiency; AIDS wasting in conjunction with simultaneous treatment with antiviral agents; short bowel syndrome in patients receiving nutritional support; and, for an Insured Person under the age of 18, growth retardation secondary to chronic renal insufficiency, Turner's Syndrome, Noonan Syndrome or Prader-Willi Syndrome. See Prescription Drug benefit for Specialty Medications for coverage provisions for growth hormone drugs.

22. Hemophilia Factor Drugs
    Hemophilia factor drugs provided during an inpatient Hospital confinement. See the Specialty Medications Program provision of the Prescription Drugs benefit for coverage provisions of outpatient hemophilia factor drugs.

23. Genetic Testing and Counseling
    Genetic Testing and Counseling for inherited mutations or susceptibility to cancer for the following conditions:
    a. Breast or ovarian cancer;
    b. Medullary Carcinoma of the Thyroid: genetic testing for "RET" proto-oncogene point mutations; and
    c. Colon Cancer.

24. Prescription Drugs:
    Once an Insured Person has satisfied the Prescription Drug Deductible each calendar year, the Policy will pay the amount of Covered Expenses in excess of the applicable Copayment. Covered outpatient prescription drugs may be provided through a Participating Pharmacy, the Mail Order Program, the Specialty Medications Program or a Non-Participating Pharmacy. **This benefit does not apply to an Insured Person eligible for Medicare.**

    Definitions:
    Average Wholesale Price means any one of the recognized published averages of the prices charged by wholesalers in the United States for a drug product they sell to a pharmacy.
    Branded Generic Drug means a prescription drug that has the same active ingredient(s) as a Brand Name Drug and a limited number of manufacturers, for which the price is similar to the price of a Brand Name Drug. For purposes of this Policy, Branded Generic Drugs are covered as Brand Name Drugs.
    Brand Name Drug means a prescription drug protected by a registered trademark.
    Compounded Drug means a drug formulation made by a pharmacist upon receipt of a valid prescription for an Insured Person from a licensed practitioner. A Compounded Drug is an alternative to a commercially available product, made by modifying a manufactured product to: adjust the dose; change the form of the drug; or prepare an alternative that does not contain preservatives, dyes or other allergens. A Compounded Drug must contain a United States Food and Drug Administration (FDA) approved legend drug that is covered by this Policy. The Copayment for a Compounded Drug will be based on the classification of the highest cost ingredient in the Compounded Drug.
    Copayment means the amount paid by the Insured Person for each Prescription Order dispensed or refilled at a Participating Pharmacy.
    Drug Utilization Review means a focused review of significant drug interactions, drug-disease precautions and appropriate drug use parameters.
    Formulary Brand Name Drug means a Brand Name Drug that is subject to the Formulary Drug Copayment. Formulary Brand Name Drugs are identified on the Formulary Brand Name Drug List, which is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles. The Pharmacy Manager will periodically review the Formulary Brand Name Drug List and adjust it to add or delete drugs. The Formulary Brand Name Drug List and any modifications thereto will be made available to Insured Persons. Insured Persons may also contact the Pharmacy Manager to determine if a particular drug is on the Formulary Brand Name Drug List. Drugs that do not appear on the Formulary Brand Name Drug List will be subject to the Non-Formulary Brand Name Drug Copayment.
    Generic Drug means a prescription drug not protected by a registered trademark.
    Maximum Allowable Cost (MAC) means the maximum cost for which a Participating Pharmacy will be reimbursed by the Administrator for selected products.
    Network means a group of independent pharmacies or chain of pharmacies having a particular agreement with the Pharmacy Manager for providing prescription drug services.
    Non-Formulary Brand Name Drug means a Brand Name Drug, which are subject to the higher Non-Formulary Brand Name Drug Copayment.
    Non-Participating Pharmacy means a pharmacy that has not entered into an agreement with the Pharmacy Manager to provide prescription drug services.
    Participating Pharmacy means an independent pharmacy or chain of pharmacies that has entered into an agreement to provide prescription drug services in the Pharmacy Manager's Network, chosen for this Policy.
    Pharmacy Manager means Medco Health Solutions, Inc.

Pharmacy Allowable Charge means the lesser of the pharmacy's usual and customary charge or the amount that would have been allowed by the Policy for the same prescription if dispensed by a Participating Pharmacy.
Prescription Drug Deductible means the amount each Insured Person must pay each calendar year for covered prescription drugs before benefits are payable. The Prescription Drug Deductible is shown in the Policy Schedule. Charges applied to the Prescription Drug Deductible will not apply to any required Copayments for covered prescription drugs, the Calendar Year Deductible or the Coinsurance Maximum amounts.
Prescription Order means a written or verbal order from a Physician to a pharmacist for a drug or device to be dispensed.
Prior Authorization means a clinical system used to manage the utilization, including Medical Necessity, of prescription drugs.
Specialty Medications means a prescription drug for which one dose costs $500 or more or for which the annual cost is $6,000 or more and for which one or more of the following is required: complex therapy for a complex disease; specialized patient training and coordination of care (services, supplies or devices) prior to therapy initiation and during therapy; unique requirements for patient compliance and safety monitoring; unique requirements for handling, shipping and storage of the drug; or potential for significant waste due to the high cost of the drug. Exceptions to the price threshold may exist based on certain characteristics of the drug or therapy that will still require the drug to be classified as a specialty drug. In addition, a follow-on-biologic or generic product will be considered a Specialty Medication if the innovator drug is a Specialty Medication.

Prior Authorization:
Certain prescription drugs will require Prior Authorization by the Pharmacy Manager before the Insured Person can obtain a covered prescription drug at a Participating Pharmacy. Prior Authorization will be required on drugs that meet one or more of the following criteria: risk of inappropriate utilization; toxicity risk unless used correctly; use outside FDA-approved indications; or high cost medications. Examples of prescription drugs that require Prior Authorization are growth hormone drugs and rheumatoid arthritis agents. A list of the drugs that require Prior Authorization can be obtained on the Pool web site, www.txhealthpool.org or by calling the Pharmacy Manager's toll free number on the back of the Insured Person's Identification Card.

Quantity Limits:
To ensure proper dosage and use, some prescription drugs may be subject to a quantity limit per prescription and/or per 30-day supply.

Benefits:
Benefits are payable for expenses for covered outpatient prescription drugs, subject to the provisions, limitations, exclusions and conditions of this Policy. Benefits are subject to the Prescription Drug Deductible and the applicable Copayment, but are not subject to the Calendar Year Deductible. Charges for outpatient prescription drugs, including charges applied to the Prescription Drug Deductible or to Copayments, do not apply to the Calendar Year Deductible or the Coinsurance Maximum amounts.

The following prescription expenses are covered when dispensed by a licensed pharmacist and prescribed by a Physician for use by an Insured Person:

a. drugs and medicines that by law can only be obtained with a Prescription Order;
b. prescription contraceptive drugs or devices, approved by the FDA, not requiring Physician office administration;
c. Injectable drugs; and
d. Diabetic equipment and supplies as follows:
    1) blood glucose monitors, including noninvasive glucose monitors and monitors for use by or adapted for the legally blind;
    2) test strips for use with a corresponding glucose monitor;
    3) lancet and lancet devices;
    4) visual reading strips and urine testing strips and tablets that test for glucose, ketones and protein;
    5) insulin and insulin analog preparations;
    6) insulin syringes, including prefilled unit dose insulin syringes or cartridges;
    7) prescription drugs and drugs available without a prescription for controlling the blood sugar level; and
    8) glucagon emergency kits.

Retail Participating Pharmacy Program:
To obtain a covered prescription drug at a Participating Pharmacy, an Insured Person must: (1) present a current, valid Identification Card; (2) provide a valid Prescription Order; (3) pay to the pharmacy the Prescription Drug Deductible, if not met, and the appropriate Copayment for the drugs received; and (4) provide the necessary recipient information and signatures required by the pharmacy. The Pharmacy Manager will pay the Participating Pharmacy an amount contractually agreed upon by the Pharmacy, less the Prescription Drug Deductible, if not met, and the appropriate Copayment. Identification Cards for each Insured Person will be provided. The Identification Card must be presented to a Participating Pharmacy in order for an Insured Person to receive full program benefits. The card will contain information needed by the Participating Pharmacy to identify the Insured Person and the Pool Policy. A Participating Pharmacy is not permitted to file claims for reimbursement unless the card is presented at the time prescription drugs are received from the Pharmacy.

The applicable drug Copayment per prescription must be paid by an Insured Person before prescription drug benefits are payable through a Participating Pharmacy. The Retail Drug Copayment per prescription is:

Generic Drugs:	$10
Formulary Brand Name Drugs:	$25
Non-Formulary Brand Name Drugs:	greater of $40 or 50% of drug cost
Specialty Medications	$100

If a Generic Drug is not available, the Insured Person will pay only the applicable Formulary Brand Name Drug or Non-Formulary Brand Name Drug Retail Copayment. If the Insured Person receives the Brand Name Drug when a Generic Drug is available, the Insured Person will be required to pay the applicable Brand Name Drug Retail Copayment plus the difference between the MAC price for the Generic Drug and the cost of the Brand Name Drug. A covered prescription will not exceed a 30-day supply, except for certain pre-packaged medications for which a greater than 30-day is provided; for these drugs, the Copayment is the applicable amount shown above, multiplied by the total number of months covered by the Prescription Order, not to exceed a 90-day supply.

Participating Pharmacies are required to file electronically their claims for reimbursement with the Pharmacy Manager. If the Participating Pharmacy, however, does not file the claim electronically and instead requires the Insured Person to pay the charges of the pharmacy and submit a paper claim to the Pharmacy Manager, the Pharmacy Manager will pay a benefit directly to the Insured Person equal to the Pharmacy Allowable Charge, after deduction of the Prescription Drug Deductible, if not met, and the applicable Copayment. A covered prescription will not exceed a 30-day supply.

Mail Order Program:
To obtain a mail order prescription, an Insured Person must: (1) ask the Physician to write a prescription for up to a 90-day supply, plus refills, if appropriate; and (2) send the prescription, including the Prescription Drug Deductible, if not met, and the appropriate Mail Order Copayment, to the Pharmacy Manager's Mail Order facility. For Mail Order Program enrollment information, the Insured Person should contact the Pharmacy Manager at the toll free number on the back of the Identification Card. Mail order refills can be placed by mail or telephone or via the Internet. Additional information is provided in the prescription drug program membership packet.

The Mail Order Copayment per prescription, for up to a 90-day supply is:

Generic Drugs:	$25
Formulary Brand Name Drugs:	$60
Non-Formulary Brand Name Drugs:	greater of $100 or 50% of drug cost

If a Generic Drug is not available, the Insured Person will pay only the applicable Formulary Brand Name Drug or Non-Formulary Brand Name Drug Mail Order Copayment. If the Insured Person receives the Brand Name Drug when a Generic Drug is available, the Insured Person will be required to pay the applicable Brand Name Drug Mail Order Copayment plus the difference between the MAC price for the Generic Drug and the Cost of the Brand Name Drug. A covered prescription will not exceed a 90-day supply.

Specialty Medication Program:
The Pharmacy Manager's Specialty Medication Program provides comprehensive services to Insured Persons who are receiving treatment for complex disease states. The program allows the Pharmacy Manager to monitor patient compliance, educate Physicians and Insured Persons as well as to provide convenient distribution of Specialty Medications. Specialty Medications can be obtained from the Pharmacy Manager's Specialty Medication program or at a Participating Pharmacy, provided that coverage for Specialty Medications at a Participating Pharmacy is limited to the original prescription and one refill, with any subsequent prescriptions or refills to be filled through the Pharmacy Manager's Specialty Medication program. Specialty Medications will be subject to the Prescription Drug Deductible, if not met, and the applicable Specialty Medications Copayment and will not exceed a 30-day supply.

Additional Pharmacy Clinical Programs:
To best manage the care of each Insured Person, additional Pharmacy Clinical Programs may be applied. These include, but are not limited to: Health Education programs; retrospective, concurrent and prospective drug utilization review activities; compliance monitoring programs; and pharmacy case management.

Appeals:
An Insured Person may appeal the decision of the Pharmacy Manager regarding coverage of a prescription drug by contacting the Pharmacy Manager, at the toll free number shown on the back of the Identification Card.

Non-Participating Pharmacy:

When an Insured Person obtains prescription drugs under a valid Prescription Order at a Non-Participating Pharmacy, the Insured Person must pay the charges of the pharmacy and submit a claim to the Pharmacy Manager. The Pharmacy Manager will pay a benefit equal to 90% of the Pharmacy Allowable Charge after deduction of the Prescription Drug Deductible, if not met, and the applicable drug Copayment. A covered prescription will not exceed a 30-day supply.

Exclusions:

In addition to the limitations otherwise listed in the Policy, Covered Expenses under this Benefit WILL NOT INCLUDE charges for:

a. Outpatient prescription drugs and medicines, devices, equipment and supplies of any kind provided to an Insured Person eligible for Medicare**.**
b. Drugs or medications that have an over-the-counter equivalent or that can be lawfully obtained without a Prescription Order, except insulin and insulin analogs.
c. Any charge incurred for the administration of prescription drugs by a Physician.
d. Drugs and substances that are Experimental or Investigational in nature.
e. Drugs taken or given while an Insured Person is confined on an inpatient or outpatient basis in a Hospital, extended care facility, Skilled Nursing Home or similar institution that has a facility for providing drugs.
f. Replacement of lost, stolen, destroyed or damaged prescriptions.
g. Vitamins that do not require a Prescription Order or have an FDA approved indication to treat a medical condition, or for which there is a non-prescription alternative.
h. Dietary supplements, cosmetic, health and beauty aids.
i. Charges for drugs in excess of the Pharmacy Allowable Charges in the area where the drugs are dispensed.
j. Therapeutic devices or appliances, support garments and other non-medical items regardless of their intended use, except as provided for treatment of diabetes.
k. Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair or otherwise.
l. Cosmetic drugs, except for acne medication, including Retin-A, Accutane, Avita and Differin, for an Insured Person under age 30 for treatment of acne vulgaris.
m. Smoking cessation products.
n. Blood and blood plasma.
o. Appetite suppressants or any other drugs prescribed for weight loss.
p. Injectable drugs for treatment of allergies.
q. Infertility medications.
r. Drugs or medications for treatment of sexual dysfunctions or disorders.
s. Biological sera.
t. Drugs or medications prescribed for an Injury or Illness arising out of employment.
u. Drugs or medications furnished by any government organization or agency unless there is an unconditional legal obligation on the part of the Insured Person to pay such expenses, except Medicaid.
v. Prescription Orders written by Physicians located outside the United States to be dispensed in the United States.
w. Drugs or medications prescribed for treatment of Chemical Dependency.
x Drugs, including abortifacients, or devices intended to terminate a pregnancy.

SECTION 9. EXCLUSIONS AND LIMITATIONS

Benefits otherwise provided by this Policy will not be payable for services or expenses or any loss resulting from or in connection with:

1. Services, supplies or treatment provided: prior to the Effective Date of coverage or after the termination date of coverage for an Insured Person; or for the portion of any Hospital or other inpatient facility admission that occurs before the Effective Date of coverage or after the termination date of coverage for an Insured Person.

2. Any service or supply that is not Medically Necessary. Items for patient convenience or comfort are not Medically Necessary, as determined by the Pool or its Administrator, including, 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, cold therapy devices, even if recommended or prescribed by a Physician or other health care provider.

3. Charges for treatment, services or supplies that are Experimental or Investigational in nature.

4. Charges for treatment, services or supplies for any condition that is a complication of a service, expense or loss that is not covered by the Policy, except as provided for Complications of Pregnancy and for the Pregnancy of a Federally Defined Eligible Individual in the Benefits Provisions.

5. Any expense determined by the Pool to be in excess of the Allowable Amount.

6. Any penalty or fee for the failure to keep a scheduled visit with a Physician; or any charges for completion of any insurance forms or for acquisition of medical records.

7. Any charge for services or supplies that are not within the scope of authorized practice of the institution or person rendering the services or supplies.

8. Any charges for physical therapy, occupational therapy or speech language therapy provided by an educational institution or school district.

9. Elective procedures, treatments or medications therefore, including but not limited to, abortions, sterilization reversals, sexual transformations, sexual dysfunctions, sexual inadequacies or disorders, or treatment for impotence.

10. Any treatment provided by an Immediate Family Member of an Insured Person, except as provided for diabetes self-management training.

11. Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or activity, or commission of or attempt to commit a felony.

12. War or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion.

13. Injury or Sickness, regardless of cause, if such charges are incurred while serving in the armed forces or auxiliary units. Premium will be refunded on a pro rata basis for any Insured Person who enters military service; all coverage for that person will be suspended until military service is over.

14. Any loss for which Worker's Compensation or Employer's Liability or Occupational Disease Benefits are payable.

15. Cosmetic or reconstructive surgery, except as provided in the Benefits Provisions. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is excluded.

16. Bariatric surgical procedures or complications related to such surgeries, even if the Insured Person has other health conditions that are related to, caused or impacted by excess weight, obesity or morbid obesity, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.

17. Aviation of any type, except for an air ambulance when Medically Necessary or as a passenger on a regularly scheduled flight on a commercial airline.

18. Charges incurred outside the United States if the Insured Person traveled to the location for the purposes of receiving medical services, drugs or supplies.

19. Care received in Veterans Administration Hospitals or facilities for a service-connected disability.

20. Services or treatment provided in a government hospital unless there is a legal obligation to pay in the absence of insurance. This does not exclude coverage for the treatment of mental health and mental retardation provided by a tax supported institution of the state of Texas, including community centers for mental health and mental retardation services, provided charges are regularly and customarily charged to non-indigent patients and if benefits under this Policy would otherwise be provided.

21. Services or treatment for which the Insured Person is not legally required to pay, except Medicaid.

22. Personal items such as TV, admitting kits, cots for Immediate Family Members, guest meals and other items that are not Medically Necessary.

23. Any dental services or supplies except as necessitated by Accidental Injury. Covered Expenses must be incurred within 12 months of the date of Injury. Injuries caused by chewing or biting down are excluded.

24. Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting thereof, radial keratotomy or any eye surgery solely for the purpose of correcting refractive defects; treatment of myopia and other errors of refraction; orthoptics or visual training.

25. Alcoholism or drug addiction.

26. Any service or supply to eliminate or reduce a dependency on or addiction to tobacco or a controlled substance.

27. Charges as a result of suicide, attempted suicide or intentionally self-inflicted Injury or Illness, while sane or insane.

28. Overdose of or Illness or Injury resulting from use of drugs, narcotics, hallucinogens, controlled or uncontrolled substances, unless administered on and according to the advice of a Physician.

29. Illness or Injury to which a contributing cause was the Insured Person's being under the influence of or resulting from the use of intoxicants, including but not limited to, alcoholic pancreatitis, alcoholic hepatitis or alcoholic cirrhosis of the liver.

30. Any service or supply associated with an autopsy or postmortem examination unless requested by Us.

31. Private duty nursing services, except as provided in the Home Health Care benefit in the Benefits Provisions.

32. Any service or supply in connection with the diagnosis or treatment of infertility, male or female, and any form or attempt of artificial fertilization or implantation, including artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer.

33. Augmentation or reduction mammoplasty, except as provided in the Benefits Provisions, or removal of prosthetic devices, except in the case of cancer.

34. Room and board charges incurred during a Hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Insured Person's physical condition or the quality of medical care provided.

35. Charges incurred in connection with a Hospital stay or other inpatient stay primarily for environmental change, physical therapy, custodial care or rest cures.

36. Transportation, except as provided for ambulance services in the Miscellaneous Services benefit in the Benefits Provisions.

37. Any services or supplies (except for Medically Necessary diagnostic and surgical procedures) for treatment or related services to the temporomandibular (jaw) joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alternation of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

38. Any service or supply received by an Insured Person as a result of or in connection with a court order, except a medical support order requiring coverage for a dependent child.

39. Any service or supply in connection with routine foot care, including the removal of warts, corns or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet in the absence of severe systemic disease; or any arch supports, orthopedic shoes or support hose, or similar type devices/appliances regardless of intended use, unless such use is for prevention of amputation in connection with treatment of diabetes.

40. Any occupational therapy services that do not consist of traditional physical therapy modalities and that are not part of an active, multi-disciplinary physical rehabilitation program designed to restore lost or impaired bodily function.

41. Any medical social services or vocational counseling.

42. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.

43. Confinement or treatment in any convalescent home, sanitarium, convalescent rest or nursing facilities or facilities primarily affording custodial or educational care or facilities for the aged, except as specifically provided in the Skilled Nursing Facility benefit in the Benefits Provisions.

44. Any service or supply used for preventive care, except as specifically provided in the Benefits Provisions.

45. Any service or supply provided for inpatient or outpatient mental health, except as specifically provided for treatment of Serious Mental Illness in the Benefits Provisions.

46. Any service or supply provided for prescription drugs, except as specifically provided in the Benefits Provisions.

47. Drugs or medications or other supplies that have an over-the-counter equivalent or that can be lawfully obtained without a Prescription Order, except insulin and insulin analogs and except amino acid-based elemental formulas, as provided in the Benefits Provisions.

48. Nutritional counseling or food supplements, except as provided for Home Infusion Therapy, Amino Acid-Based Formulas, or treatment of Phenylketonuria (PKU) or other heritable diseases in the Benefits Provisions.

49. Growth hormone drugs or treatments, except as provided in the Benefits Provisions.

50. Hemophilia factor drugs, except as provided in the Benefits Provisions.

51. Except as provided for Specialty Medications in the benefit for Prescription Drugs or if provided during an inpatient Hospital confinement: Immune Globulins; Infused Rheumatoid Arthritis drugs; Alpha-1 therapy drugs; drugs to treat Fabrys disease; drugs to treat Mucopolysaccharidosis, including Aldurazyme and Naglazyme; drugs to treat Gaucher's Disease, including Cerezyme; drugs to treat Hunter Syndrome, including Elaprase; and drugs to treat Pompe Disease, including Myozyme. This list of restricted infused medications is subject to change. See the Pool's web site for updates (www.txhealthpool.org).

52. Any services for transplants or replacements, except as specifically provided in the Benefits Provisions.

53. Genetic testing or counseling, except as provided in the Benefits Provisions, biofeedback, travel expenses, holistic therapies, acupuncture, hypnosis or massage therapy.

54. Any services, supplies or medications used for the primary purpose of evaluation for or diagnosis or treatment of the condition known as Idiopathic Environmental Intolerance (IEI) or Multiple Chemical Sensitivities (MCS) or Environmental Sensitivities (ES) or any other term by which these conditions may be known.

55. Charges for pregnancy or maternity care, including but not limited to normal deliveries, elective caesarean sections and elective abortions, except as provided for Complications of Pregnancy or for the Pregnancy of a Federally Defined Individual in the Benefits Provisions.

56. Charges for Vagus Nerve Stimulation (VNS), except for treatment of partial-onset seizures refractory to medical therapy.

SECTION 10. HOW TO FILE A CLAIM

Notice of Claim: You must tell the Administrator in writing of a claim for benefits within 20 days after You have had an Injury or Illness for which You are presenting a claim or as soon as is reasonably possible. You may give the Administrator the notice or You can have someone give it for You. The notice should give Your name and either Your Policy number or identification number. The notice should be sent directly to the Administrator.

Claim Forms: When the Administrator receives Your notice of claim for benefits, the Administrator will send You forms to complete. If these forms are not sent to You in 15 days, You will have met the requirements of Your proof of claim, if You notify the Administrator in writing about the expenses for which You are making a claim for benefits within the time limit for filing proof of claim.

Proof of Your Claim: You must give the Administrator written proof of all expenses You have incurred for which You are claiming benefits. This proof must be given the Administrator within 90 days after You have incurred the expense or, if this is not possible, as soon as is reasonably possible. Your proof must, however, be given the Administrator within one year after the time proof is otherwise required, unless You are not legally competent to act.

SECTION 11. PAYMENT OF CLAIMS

Payment of Claims: The Administrator will pay the benefits upon receipt of due written proof of Your claim.

Assignment of Benefits: Benefits will be paid to You or to whom You assign them in writing. If You are no longer living and had not assigned the benefits, they will be paid to Your estate. The Administrator will honor an assignment of benefits filed with the Administrator. Neither the Pool nor the Administrator assumes any responsibility for the validity of an assignment.

Subrogation and Reimbursement: The Pool is subrogated to the rights of a person, covered by the Policy, to recover against a third party for costs for an Injury or Illness, for which the third party is liable under contract, tort law, or other law, that have been paid by the Pool on behalf of the Insured Person and the Pool may enforce that liability on behalf of the Insured Person.

Benefits are not payable under this Policy for an Injury or Illness for which a third party may be liable under contract, tort law, or other law, provided the Pool may advance, to a Insured Person, the benefits provided under the Policy for medical expenses resulting from the Injury or Illness, subject to the Pool's right to subrogation and reimbursement.

The amount recovered by a Insured Person in an action against a third party, who is liable for the Injury or Illness, must be used to reimburse the Pool for medical expenses that have been advanced under this Policy. The amount of reimbursement will not be reduced by the application of the doctrine, established at common law, relating to adequate compensation of insureds, commonly referred to as the "made whole" doctrine. The Pool shall treat any amount, recovered by a Insured Person in an action against a third party who is liable for any Injury or Illness, which exceeds the amount of the reimbursement required, as an advance against future benefits for the Injury or Illness that the Insured Person would otherwise be entitled to receive under the Pool Policy.

If the amount treated as an advance is adequate to cover all future medical costs for the Insured Person's Injury or Illness, the Pool is not required to resume the payment of benefits. If the advance is insufficient, the Pool shall resume the payment of benefits when the advance is exhausted.

The Pool's recovery includes: the amount recovered by the Pool in the action; and the amount of the Insured Person's total recovery that must be used to reimburse the Pool or that is treated as an advance for future medical costs. If the Pool's interest is not actively represented by an attorney in a third party action, the Pool shall pay a fee to an attorney representing the Insured Person in the amount agreed on between the attorney and the Pool. In the absence of an agreement, the court shall award to the attorney, payable out of the Pool's recovery, a reasonable fee for recovery of the Pool's interest, not to exceed one third (1/3) of the Pool's recovery, and a proportionate share of reasonable incurred expenses. An attorney who represents a person covered by the Pool and is also to represent the interest of the Pool, must make a full written disclosure to the Insured Person before employment as an attorney by the Pool. The Insured Person must acknowledge the disclosure and consent to the representation. A signed copy of the disclosure will be provided to the Insured Person and the Pool. A copy of the disclosure, with the Insured Person's consent, must be filed with the pleading before a judgment is entered and approved by the court. The attorney may not receive a fee under this section to which the attorney is otherwise entitled under an agreement with the Pool, unless the attorney complies with the requirements of this section. If an attorney, representing only the Pool's interest, actively participates in obtaining a recovery, the court shall award and apportion between the Insured Person’s and the Pool's attorneys a fee payable out of the Pool's subrogation recovery. In apportioning the award, the court shall consider the benefit accruing to the Pool as a result of each attorney's service. However, the total attorneys' fees may not exceed one third (1/3) of the Pool's recovery.

Right to Recover an Overpayment: If We make any overpayment, We can recover what We did not owe from the person to whom We made the payment or from any other appropriate person. We have this right even if the mistake was Our fault. If the overpayment was made to You, We have the right to deduct it when We pay Your claims. By “overpayment,” We mean any payment or part of any payment that is not authorized by the terms of this Policy. We do not have the right to recover from You any overpayment that was fraudulently obtained by another person without Your knowledge.

Payment to State: A claim for benefits under the Policy will not be reduced or denied because services are provided to an Insured Person who is eligible for or receiving medical assistance pursuant to The Medical Assistance Act of 1967, as amended. Any benefits due under this Policy will be paid to the Texas Department of Human Resources for the actual cost of medical expenses it pays through medical assistance for an Insured Person, if the person would otherwise be entitled to payment of benefits for such medical expenses. Benefits so paid will, in no event, exceed benefits otherwise payable under this Policy. Any benefits due for expenses not paid by such Department will be paid as provided in this Policy.

Benefits will be paid to the Texas Department of Human Services when written notice is provided to Us that the Department is paying benefits on behalf of an insured child under Chapter 31 or 32 of the Human Resources Code and provided the parent covered by this Policy has possession of or access to the child, pursuant to a court order, or is not entitled to access to or possession of the child and is required by the court to pay child support. We must receive notice by an attachment to the claim when first submitted that the benefits are to be paid directly to the Texas Department of Human Services.

Other Insurance: An Insured Person may have other valid coverage that applies to a loss covered by this Policy. The benefits otherwise payable by this Policy will be reduced by amounts paid or payable by such other coverage. Other valid coverage means other Health Benefit Plan coverage or Health Benefit Plan coverage arrangement, hospital and medical expense benefits under workers’ compensation coverage or automobile insurance, whether provided on the basis of fault or no-fault, and hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program, including Medicare. For any Insured Person covered by Medicare Part A, other valid insurance will include benefits provided by Medicare Part B, whether or not the person is covered under Part B.

SECTION 12. PREMIUMS

Premium Changes: Your premium is expected to change. The change will be based on an Insured Person's attained age, the primary insured's move to an area with a different rating factor, a change in coverage or Our revised schedule of premium rates. We can apply revised rates only if We do the same thing on all Pool policies of the same form number, with the same provisions and benefits, issued to persons of the same classification in the same geographic area of the State of Texas. The Administrator will notify You at least 30 days in advance of the change. Your premium rate is based on Your age and the ages of other Insured Persons under the Policy. If an age is misstated on the application or if Your premium rate is based on Your statement that You or another Insured Person is not a tobacco user at the time of application and We discover otherwise, Your premium rate will also change, retroactively for twelve months prior to the date We determine that an age was misstated or the statement regarding tobacco use was not true.

Premium Payment: The premium must be paid on or before the date it is due or during the Grace Period. Otherwise, the Policy shall terminate without further notice. Such termination shall not affect any claim incurred prior thereto.

Grace Period: The Grace Period is the 31 days following the date the premium is due. The Policy stays in force during the Grace Period, subject to Our right to terminate the Policy in accordance with the Termination provisions. We have the right to deduct the amount of any unpaid premium from any benefits payable to You or on Your behalf for charges incurred during the Grace Period. This Policy will terminate if the premium is not paid by the end of the Grace Period. If the Administrator gives You a 30 day notice of nonrenewal or cancellation, there will be no Grace Period.

SECTION 13. GENERAL PROVISIONS

Entire Contract; Changes: This Policy, the application and any other attachment are the entire contract. No agent may change it in any way. Only an executive officer of the Pool may make a change and the change must appear in writing as a part of this Policy. The Pool has the right to change the Policy, provided it provides 30 days prior notice of such change to You.

Policy not Transferable: This Policy covers only those it names as Insured Persons. Its benefits are not transferable.

Time Limit on Certain Defenses: We will not void this Policy or deny a claim for loss for any expenses incurred after two years from the effective date of coverage because of fraudulent misstatements made in the application.

We will not reduce or deny a claim for loss that begins after 12 months from the effective date of coverage of an Insured Person because the disease or physical condition existed before that person's effective date of coverage.

Physical Examination: We have the right to require that any Insured Person have a physical examination as often as it may be reasonably necessary to prove a claim. We will pay for any physical examination We require.

Legal Actions: You must wait for at least 60 days after You have given Us due proof of any claim for benefits in writing before You can bring a legal action to recover under this Policy. You have 3 years after the date proof of claim for benefits is filed to bring a legal action.

Right to Obtain and Release Medical Information: When You signed Your application for coverage under this Policy, You agreed that in the normal course of business, We or Our Administrator may obtain, from any relevant person or entity, information relating to an Illness, Injury or impairment for which benefits are claimed under this Policy. We, in the normal course of business, may furnish to Our Administrator historical data setting forth the volume, nature and cost of health care services paid by Us on Your behalf. We agree that all such data will be treated as confidential and that all reasonable steps shall be taken by Us to maintain the confidentiality of the data.

In the event that any local, state or federal law or regulation shall prohibit Us from releasing data to our contractors under this provision, this provision shall be amended by operation of law.

Not Responsible for Quality of Care: We are not responsible for the quality of health care any person receives from any Hospital, other facility or Physician.

Grievance Procedure: If a claim is denied, You will receive written notice of the denial, together with the specific reason for the denial from Our Administrator. You may request a review of that denial by the Administrator and, after the review by the Administrator, You may file a grievance with the Pool's Grievance Committee. If You wish to request a review, contact the Administrator for instructions and time requirements for filing Your request.

SECTION 14. DEFINITIONS

Church Plan has the meaning assigned by Section 3(33), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002 (33)).

Cosmetic Surgery means surgery that is primarily for the purpose of improving appearance and does not, other than incidentally, correct or improve a functional impairment.

Creditable Coverage means, with respect to an individual, coverage of the individual provided under any of the following: a Group Health Plan; a Health Benefit Plan; Part A or Part B, Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.) (Medicare); Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) (Medicaid), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) (the program for pediatric vaccines); 10 U.S.C. Section 1071 et seq. (Uniformed Services Former Spouses' Protection Act); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health benefits plan offered under 5 U.S.C. Section 8901 et seq. (Federal Employees Health Benefits Act of 1959); a public health plan as defined in federal regulations; a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)); a state child health plan provided under Title XXI, Social Security Act (State Children's Health Insurance Program) (42 U.S.C. Section 1397aa et seq.) and short-term limited duration coverage (Health Benefit Plan coverage that has a specified contract expiration date within 12 months of the effective date of the contract, including any extensions that may be elected by the insured without the insurance company's consent).

Creditable Coverage does not include coverage under: accident-only insurance (including accidental death and dismemberment insurance); disability income insurance or a combination of accident-only and disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance (including mortgage insurance); coverage for onsite medical clinics; other coverage that is similar to the coverage under which benefits for medical care are secondary or incidental to other insurance benefits and as specified by federal regulations; if offered separately, coverage that provides limited scope dental or vision benefits; if offered separately, long term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits or any combination of those coverages or benefits; if offered separately, coverage that provides other limited benefits as specified by federal regulations; if offered as independent, noncoordinated benefits, coverage for specified disease or illness; if offered as independent, noncoordinated benefits, hospital indemnity or other fixed indemnity insurance; Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C Section 1395ss) (Medicare and Medicaid Patient and Program Protection Act of 1987); coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.) (Uniformed Services Former Spouses' Protection Act); or similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate or contract of insurance.

Dependent means a person, under age 65, whose primary residence is with You and who: has been for at least 30 days and remains a legal resident of Texas; is a United States citizen or a permanent legal resident of the United States for at least three continuous years; and is described below:

1. Your spouse;

2. Your unmarried child who is under age 25;

3. Your unmarried step-child who is under age 25;

4. an unmarried child adopted by You, including a child You are seeking to adopt, who is under age 25, for the first 31 days from the date of adoption or initiation of a suit for adoption. After 31 days, such child will remain a Dependent under the Policy only if We receive notice of the adoption or initiation of suit before the next premium due date following the 31 days after adoption or initiation of suit and the required premium is paid;

5. Your unmarried grandchild who is dependent on You for Federal income tax purposes and under age 25 (coverage for a grandchild will not terminate solely because the Insured child is no longer Your dependent for Federal income tax purposes);

6. a child of any age who is disabled and dependent on You; or

7. a newborn child born to You for the first 31 days after birth. After 31 days, such child will remain a Dependent under this Policy only if We receive notice of birth before the next premium due date following the 31 days after birth and the required premium is paid.

Dependent also means an unmarried child, under age 25 for whom You have received a court or administrative order to provide medical support, including Health Benefit Plan coverage.

Educational means that the primary purpose of the service or supply is to provide the Insured Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

"Training in the activities of daily living" does not include training directly related to treatment of Illness or Injury that resulted in a loss of a previously demonstrated ability to perform those activities.

Emergency Care means health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset or severity including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, Illness or Injury is of such a nature that failure to get immediate medical care could result in: (1) placing the Insured Person's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational means a medical, surgical and/or other procedure, service, product, drug or device, including implants, if the Administrator determines that one or more of the following is true:

1. Its use is mainly limited to laboratory and/or research.

2. The service or supply is under study or in a clinical trial to evaluate its maximum tolerated dose, toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to, phase I, II and III clinical trials.

3. Prevailing opinion within the appropriate specialty of the United States medical profession is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy as compared with standard means of treatment and diagnosis.

   The Administrator will determine if this item 3. is true based on:
   a. Published reports in authoritative medical literature; and
   b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institute of Health and the United States Food and Drug Administration (FDA).

4. In the case of a drug, a device or other supply that is subject to FDA approval:
   a. It does not have FDA approval; or
   b. It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or
   c. It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered experimental or investigational if they are determined to be:
      i) included in substantially accepted peer-reviewed medical literature, such as: The American Medical Association Drug Evaluations; The American Hospital Formulary Service Drug Information; The United States Pharmacopoeia Information; and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;
      ii) included in a prescription drug reference compendium approved by the Texas Commissioner of Insurance; or
      iii) in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established, based on supportive clinical evidence in peer-reviewed medical publications; or
   d. It has FDA approval, but the consensus of opinion within the appropriate specialty of the United States medical profession is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy as compared with standard means of treatment and diagnosis.

5. The Physician's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.

6. Research protocols indicate that the service or supply is experimental or investigational. This subsection applies for protocols used by the Insured Person's Physician as well as for protocols used by other Physicians studying substantially the same service or supply.

Family Member means a parent, step-parent, grandparent, brother or sister of a child who is an eligible individual and enrolled in Pool coverage, provided the Family Member: is under age 65; resides with the child; has been for at least 30 days and remains a legal resident of Texas; and is a United States citizen or a permanent legal resident of the United States for at least three continuous years.

Federally Defined Eligible Individual means an individual who meets all of the following requirements:

1. As of the date on which the individual applies for Pool coverage, the individual's aggregate period of prior Creditable Coverage is 18 months or more;

2. The individual's most recent prior creditable coverage was under a Group Health Plan, Church Plan or Governmental Plan;

3. The individual is not eligible for coverage under a Group Health Plan, Part A or Part B, Title XVIII, Social Security Act (42 U.S.C. Section 1395c et seq.) (Medicare) or a state plan under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) (Medicaid) or any successor program and who does not have other Health Benefit Plan coverage;

4. The most recent Creditable Coverage was not terminated for fraud or for nonpayment of premiums or contributions;

5. If offered, the individual elected and exhausted continuation coverage under the Texas Insurance Code or under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), as applicable.

Governmental Plan has the meaning assigned by Section 3(32), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002 (32), and includes any United States governmental plan.

Group Health Plan means an employee welfare benefit plan as defined by Section 3(1), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002 (1)), to the extent that the plan provides health benefit plan coverage to employees or their dependents as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise.

Health Benefit Plan means: an individual or group health benefit plan and includes: a hospital or medical expense incurred policy; coverage of medical or health care services offered by a group hospital service corporation operating under Chapter 842, Texas Insurance Code; a fraternal benefit society operating under Chapter 885, Texas Insurance Code; a stipulated premium company operating under Chapter 884, Texas Insurance Code; a health maintenance organization; a multiple employer welfare arrangement subject to Chapter 846, Texas Insurance Code; an approved nonprofit health corporation that holds a certificate of authority under Chapter 844, Texas Insurance Code; or any other health care plan or arrangement that pays for or furnishes medical or health care services by insurance or otherwise.

Health Benefit Plan does not include

1. One or more or any combination of the following:
   a. coverage only for accident or disability income insurance or any combination of those coverages;
   b. credit-only insurance;
   c. coverage issued as a supplement to liability insurance;
   d. liability insurance, including general liability insurance and automobile liability insurance;
   e. workers' compensation or similar insurance;
   f. coverage for on-site medical clinics;
   g. automobile medical payment insurance;
   h. insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance; or
   i. other similar insurance coverage, specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits;

2. The following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage:
   a. limited scope dental or vision benefits;
   b. benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits; or
   c. other similar, limited benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191); or

3. The following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
   a. coverage only for a specified disease or illness;
   b. hospital indemnity or other fixed indemnity insurance.

Illness means sickness, disease or Complications of Pregnancy.

Immediate Family Member means a person related to an Insured Person by blood, marriage or adoption.

Injury or Accidental Injury means accidental bodily injury sustained by an Insured Person that is the direct cause of the loss, independent of disease, bodily infirmity or any other cause.

Insured Person means You and Your Dependents and Family Members, if insured under the Policy.

Insurance Company means an insurance company; a health maintenance organization; an approved nonprofit health corporation; a fraternal benefit society; a stipulated premium insurance company; a group hospital service corporation; a multiple employer welfare arrangement; or any other entity providing a plan of Health Benefit Plan coverage or health benefits subject to state regulation.

Loss means those Covered Expenses incurred by an Insured Person while this Policy is in force for the Medically Necessary treatment of an Illness or Injury.

Medically Necessary means services or supplies that are Covered Expenses, prescribed by Your Physician, to diagnose or treat an Injury or Illness, that are known to be safe and effective by the majority of licensed Physicians who diagnose or treat that Injury or Illness. The Administrator will determine whether a service or supply is Medically Necessary, considering 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 other health care provider may have prescribed a service or supply, such service or supply may not be Medically Necessary within this definition. Medically Necessary services must be:

1. provided at appropriate facilities and at the appropriate levels of care for the treatment of the Insured Person's medical condition;

2. not provided primarily for the convenience of the Insured Person, the Insured Person's Immediate Family Member, the treating Physician or the facility providing the service;

3. consistent with health care practice guidelines and standards that are issued by professionally recognized health care organizations or governmental agencies;

4. not primarily educational, experimental or investigative;

5. consistent with Your symptoms, diagnosis or treatment; and

6. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency.

Physician means a doctor of medicine, doctor of osteopathy, advance practice nurse, doctor of chiropractic, doctor of dentistry, doctor of optometry, doctor of podiatry, licensed audiologist, licensed chemical dependency counselor, licensed dietician, licensed marriage and family therapist, licensed master social worker-advanced clinical practitioner, licensed nurse first assistant, licensed occupational therapist, licensed physical therapist, licensed professional counselor, licensed psychological associate, licensed speech-language pathologist, licensed surgical assistant, physician assistant or psychologist, who is practicing within the scope of his/her license and applicable laws and who is not an Immediate Family Member of the Insured Person.

Policy Schedule means the benefit schedule set forth in the Policy.

Pool means the Texas Health Insurance Pool.

Preexisting Condition means a disease or condition: for which the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care or treatment during the six months before an Insured Person's effective date of coverage; or for which medical advice, care or treatment was recommended or received during the six months before an Insured Person's effective date of coverage. Preexisting Condition includes a preexisting pregnancy or a complication of a preexisting pregnancy, whether the complication occurs before or after the effective date of coverage. Preexisting Condition does not include genetic information, in the absence of a diagnosis of the condition related to the genetic information.

Retail Health (Walk-in) Clinic means a clinic that treats certain common, non-emergency conditions, such as sinus infections or upper respiratory infections, bladder infections, strep throat, pink eye or styes, minor injuries, such as burns and sprains, and skin conditions, such as eczema. A clinic may be staffed by a licensed nurse practitioner or physician's assistant, who is specially trained to work in clinics and can write a prescription, if necessary, with a doctor, employed by the clinic, available on call to the nurse

practitioner if a consultation is necessary or an emergency arises. The clinic may be located in stores or pharmacies and may have evening and weekend hours.

Significant Break in Coverage means a period of 63 consecutive days during all of which the individual does not have Health Benefit Plan coverage, except that a waiting period or an affiliation period is not considered in determining a Significant Break in Coverage.

Urgent Care Clinic is a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent Care Clinics are primarily used to treat patients who have non-life threatening, acute injuries or illnesses, that require immediate care, but are not serious enough to warrant a visit to an emergency room. A clinic may be staffed by doctors trained in primary or emergency medicine.

We, Us and **Our** means the Pool or our Administrator acting on behalf of the Pool.

You and **Your** means the primary insured. If the primary insured is a minor child, You means the person who applied for coverage and who pays the premium on behalf of the child; however, benefits are not payable for such person unless that person is also named as an Insured Person on the application.