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Texas Register

Volume 18, Number 82, October 29, 1993 Page 7750-7881

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Proposed Sections

(continued)

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Texas Register

a section of the
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Texas Register, ISSN 0362-4781, is published semi-weekly 100 times a year except July 30, November 30, December 28, 1993. Issues will be published by the Office of the Secretary of State, 1019 Brazos, Austin, Texas 78701. Subscription costs: one year - printed, $95 and electronic, $90; six-month printed, $75 and electronic, $70. Single copies of most issues are available at $5 per copy.

POSTMASTER: Please send form 3579 changes to the *Texas Register*, P.O. Box 13824, Austin, TX 78711-3824.

How to Use the Texas Register

Information Available: The 10 sections of the *Texas Register* represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Sections - sections adopted by state agencies on an emergency basis.

Proposed Sections - sections proposed for adoption.

Withdrawn Sections - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Sections - sections adopted following a 30-day public comment period.

Open Meetings - notices of open meetings

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the *Texas Register* is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 18 (1993) is cited as follows: 18 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "18 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 18 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the *Texas Register* office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using *Texas Register* indexes, the *Texas Administrative Code*, section numbers, or TRD number.

Texas Administrative Code

The *Texas Administrative Code* (*TAC*) is the official compilation of all final state agency rules published in the *Texas Register*. Following its effective date, a rule is entered into the *Texas Administrative Code*. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the *TAC*. West Publishing Company, the official publisher of the *TAC*, releases cumulative supplements to each printed volume of the *TAC* twice each year.

The *TAC* volumes are arranged into Titles (using Arabic numerals) and Parts (using Roman numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency. The *Official TAC* also is available on WESTLAW, West's computerized legal research service, in the TX-ADC database.

To purchase printed volumes of the *TAC* or to inquire about WESTLAW access to the *TAC* call West **1-800-328-9352.**

The Titles of the *TAC*, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the *TAC* scheme, each section is designated by a *TAC* number. For example in the citation 1 TAC §27.15:

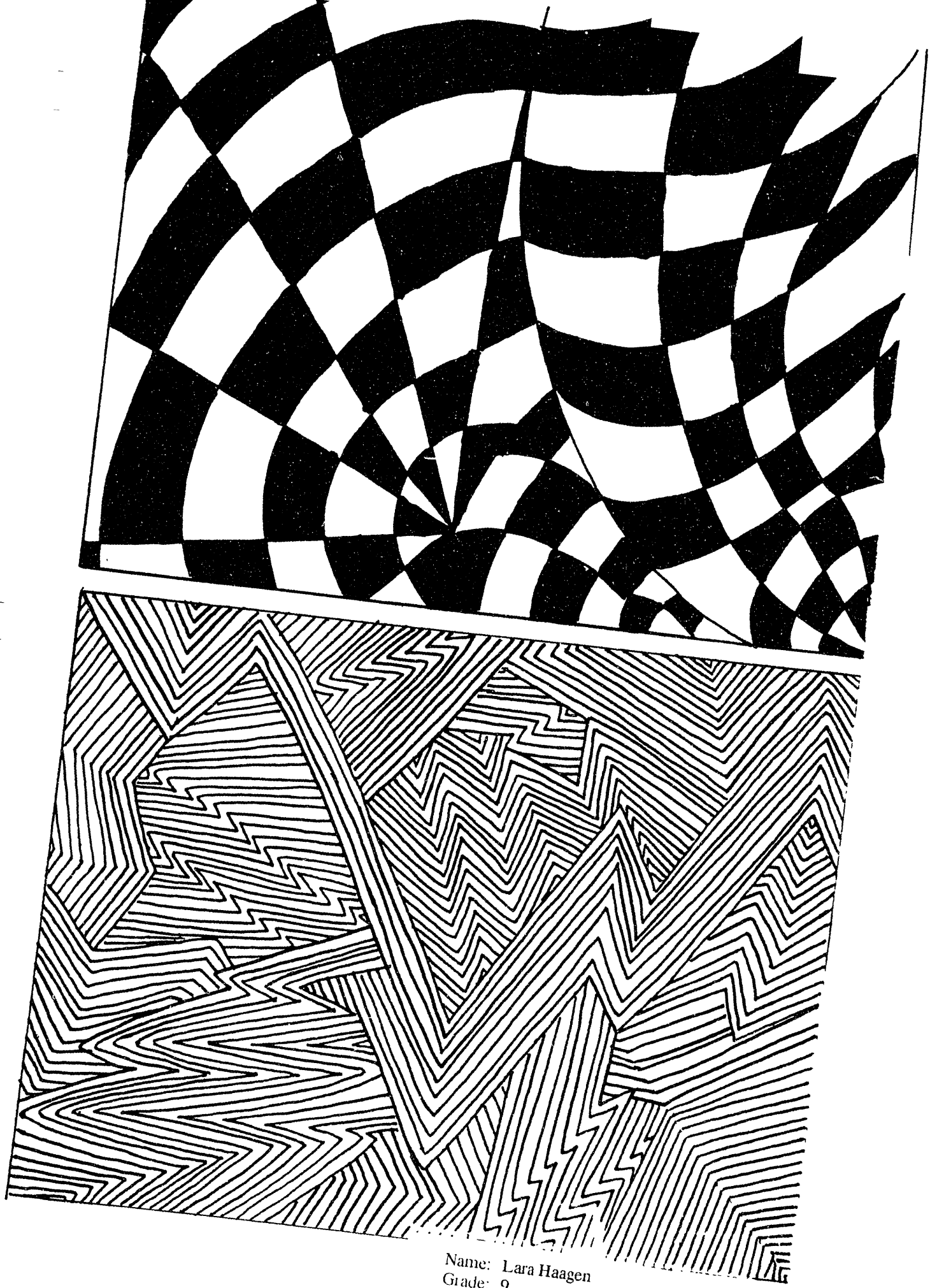
1 indicates the title under which the agency appears in the *Texas Administrative Code*; *TAC* stands for the *Texas Administrative Code*; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the *Texas Administrative Code*, please look at the *Table of TAC Titles Affected*. The table is published cumulatively in the blue-cover quarterly indexes to the *Texas Register* (January 22, April 16, July 13, and October 12, 1993). In its second issue each month the *Texas Register* contains a cumulative *Table of TAC Titles Affected* for the preceding month. If a rule has changed during the time period covered by the table, the rule's *TAC* number will be printed with one or more *Texas Register* page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The *Table of TAC Titles Affected* is cumulative for each volume of the *Texas Register* (calendar year).

Update by FAX: An up-to-date *Table of TAC Titles Affected* is available by FAX upon request. Please specify the state agency and the TAC number(s) you wish to update. This service is free to *Texas Register* subscribers. Please have your subscription number ready when you make your request. For non-subscribers there will be a fee of $2.00 per page (VISA, MasterCard) (512) 463-5561



Name: Lara Haagen
Grade: 9
School: Bailey Junior High, Arlington ISD

Figure 43

EXCLUSIONS AND LIMITATIONS
STANDARD HEALTH PLAN

The Policy does not cover expenses incurred resulting from:

a. Any service or supply which is not Medically Necessary.

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

c. Any expense which is in excess of the Reasonable and Customary charges.

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

e. Reversal of sterilization, or medical care or surgery to change gender.

f. Elective abortions. A voluntary interruption of a pregnancy is not considered an elective abortion if the life of an Insured Person would be endangered if the fetus were carried to term, the pregnancy is a result of a criminal act such as rape or incest, or there is a diagnosis of a non-viable fetus. Benefits for treatment of complications arising from or as a result of an elective abortion shall be payable on the same basis as any other Illness.

g. Any loss, expense or charge resulting from the Insured Person's active participation in a riot or inciting a riot.

h. Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity.

i. Any treatment provided by any Immediate Family Member (you, your spouse, or your parent, brother or sister) or provided by the Employer.

j. Any act of war, declared or undeclared.

2055 EXC.STD

k. Or during active service in the Armed Forces or auxiliary units. Upon receipt of written request, a prorata refund of premiums will be provided for the period an Insured Person is in the military service on full-time active duty.

l. Injury or Illness arising out of employment for wage or profit.

m. Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under the Policy, reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn Child. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered a cosmetic surgery for purposes of this exclusion.

n. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Insured Person has other health conditions which might be helped by a reduction of obesity or weight.

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

p. Care received in Veterans Administration hospitals for service connected disabilities.

q. Services or treatment provided in a government hospital unless the Insured Person is legally required to pay except 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.

r. Service or treatment for which the Insured Person is not legally required to pay.

s. Personal items such as TV, admitting kits, cots for family members, guest meals and other items which are not Medically Necessary.

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

u. Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting (unless otherwise covered under a preventive care benefit).

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

w. Private duty nursing services, except for covered Home Health Care services.

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

y. Any service or supply in connection with any transplant, except as otherwise provided for under Covered Services.

z. Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use.

aa. 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.

bb. Transportation, except for local ground ambulance service or air ambulance service for Emergency Care.

cc. Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Policy.

dd. Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service.

ee. 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 and chronic foot strain, in the absence of severe systemic disease.

ff. Any medical social services or vocational counseling.

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

For Chapter 20 companies only:

hh. Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

ii. Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

Figure 44

Alternate Benefits for Chemical Dependency

Chemical Dependency Benefits are limited to a lifetime maximum of three separate series of treatments for each Insured Person.

A series of treatments is a planned, structured and organized program to promote chemical free status which may include different facilities or modalities and is complete when the Insured Person is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of 30 days.

Any necessary care and treatment provided in a Chemical Dependency Treatment Center shall be determined as if care and treatment was provided in a Hospital.

2055 ACD

FORMS COMMON TO MORE THAN ONE PLAN

Figure 45

ALTERNATE COST CONTAINMENT PROVISIONS

[LARGE CASE MANAGEMENT:

If it will result in less expensive treatment, we may be able to approve services under an alternate treatment plan. An alternate treatment plan may include services or supplies otherwise limited or excluded by the policy. It must be mutually agreed to by us, you and your Physician, Provider or Other Healthcare Practitioner. Any benefits payable for services covered under an alternate treatment plan are subject to the Maximums shown in the Schedule.]

[SECOND OPINION REQUIREMENTS:

You must obtain a second opinion which confirms the need for any scheduled surgical procedure. If the second opinion does not agree, then you may obtain a third opinion. Eligible Expenses related to a second or third opinion will be payable at [100%] of the Reasonable and Customary charges and the deductible and copayment will be waived.

If you have surgery without obtaining a confirming second or third opinion, the Percentage Payable will be reduced to [50%]. **ANY SERVICES OR SUPPLIES THAT ARE NOT MEDICALLY NECESSARY ARE NOT COVERED UNDER THE POLICY.**

The second opinion requirement will be waived for Emergency Care.]

2055 ACC

Figure 46

CONTINUATION/CONVERSION PROVISIONS

An Insured Person whose coverage terminates shall have the right to conversion or continuation under the Policy as outlined below. In order to be eligible for this option, the Insured Person must:

1. have been continuously covered under the Policy for at least three consecutive months prior to termination; and
2. coverage terminated for any reason other than involuntary termination for cause.

There is no right of conversion or continuation if:

1. the termination of coverage occurred because of either nonpayment of premium or any discontinued group coverage was replaced by similar group coverage within 31 days of the discontinuance; or
2. the Insured Person is or could be covered by Medicare; or
3. the Insured Person has similar benefits under another group or individual plan whether insured or uninsured;
4. the Insured Person is eligible for similar benefits under another group plan whether insured or uninsured; or
5. similar benefits are provided for or available to the Insured Person under any state or federal law.

Written application and payment of the first premium must be made within 31 days after the date coverage terminates.

No evidence of insurability is required. Each Insured Person may select one of the following options:

Option 1. A conversion policy providing the same coverage and benefits as provided under the group Policy. If this option is selected, lifetime maximums shall be computed from the initial effective date under the Health Benefit Plan; or

Option 2. A conversion policy with lesser coverage and benefits. If this option is selected, the benefits and premium will be provided in accordance with the minimum standards for conversion policies.

2055 COP

A conversion policy will be effective on the day after termination of coverage under the Policy. You will be given credit for any satisfaction under the Policy of waiting periods or limitations for any Preexisting Condition.

Option 3. Continuation of coverage under the group plan. If this option is selected, continuation will be permitted for a maximum of six months. The premium rate will be 102% of the group premium. The premium will be payable in advance to the Employer or group Policyholder on a monthly basis. Continuation may not terminate until the earliest of:

a. six months after the date the election is made;
b. the date you fail to make timely premium payments;
c. the date on which you are or could be covered under Medicare;
d. the date on which you are covered for similar benefits under another group or individual policy;
e. the date on which you are eligible for similar benefits under another group plan;
f. the date on which similar benefits are provided for or available to you under any state or federal law.

[If the Policy terminates in its entirety before the end of the continuation period, your coverage will continue until the time otherwise specified.] [If the Policy terminates in its entirety before the end of the continuation period, you may choose to convert your coverage in accordance with Options 1 or 2.]

Additional Continuation/Conversion for Certain Dependents

If coverage terminates as the result of an Employee's death, retirement or divorce, a Dependent's coverage can continue. The Insured Person must have been covered under the Health Benefit Plan for at least one year, unless the Dependent is an infant under one year of age. Continuation does not require evidence of insurability.

Continuation under this provision will not apply if continuation is required under the Consolidated Omnibus Budget Reconciliation Act of 1985. In addition, continuation is not available when coverage terminates due to any of these circumstances:

1. The Policy is canceled or
2. The Dependent fails to make any timely premium payments.

Continuation ends at the earliest of the date:

1. Three years;
2. The Insured Person fails to make timely premium payments;

3. The Insured Person becomes eligible for coverage under any other group plan providing similar benefits;
4. The Policy is canceled.

Notification Requirements. The Dependent must notify the Policyholder within 15 days of the Employee's death, retirement, or divorce. The Policyholder will immediately [within 5 working days] provide written notice to the Dependent of the right to continue coverage and will send the election form, and instructions for premium payment.

Within 60 days of the Employee's death, retirement, or divorce, the Dependent must give written notice to the Policyholder of the desire to exercise the right of continuation or the option expires. Coverage remains in effect during the 60-day period provided premium is paid.

Any Dependent qualifying for continuation of coverage under this provision may elect a converted policy instead of such continuation of group insurance. If the Dependent has elected continuation under this provision, the Dependent will have the option of a conversion coverage at the end of the maximum continuation period. All conversion provisions described above in Option 1 and Option 2 will apply.

Figure 47

COORDINATION OF BENEFITS

APPLICABILITY:

This Coordination of Benefits (COB) provision applies to This Plan when an Insured Person has health care coverage under more than one Plan. **Plan** and **This Plan** are defined below. [This provision will only apply for the duration of your employment with the Employer.]

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of This Plan are determined before or after those of another plan. The benefits of This Plan:

1. Shall not be reduced when This Plan determines its benefits before another plan; but

2. May be reduced when another plan determines its benefits first.

DEFINITIONS:

Plan is any of these which provides benefits or services for, or because of , medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.

2. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage under 1. or 2. is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

This Plan is the part of the Policy that provides benefits for health care expenses.

Primary Plan/Secondary Plan: The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan covering the person.

2055 COB

When This Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering of the other plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because ot the other plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

Allowable Expense means a Medically Necessary, Reasonable and Customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the Insured for whom claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because an Insured Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.

Claim Determination Period means a Policy Year. However, it does not include any part of a year during which an Insured Person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

ORDER OF BENEFIT DETERMINATION RULES:

General

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other plan, unless:

1. The other plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other plan.

Rules

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

1. Non-Dependent/Dependent - The benefits of the plan which covers the Insured as an Employee, member or subscriber are determined before those of the plan which covers the Insured Person as a Dependent; except that: if the Insured Person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security and implementing regulations, Medicare is

   a. Secondary to the plan covering the Insured Person as a Dependent and
   b. Primary to the plan covering the Insured Person as other than a Dependent (e.g. a retired employee),

   then the benefits of the plan covering the Insured Person as a dependent are determined before those of the plan covering that Insured Person as other than a Dependent.

2. Dependent Child/Parents Not Separated or Divorced - Except as stated in Paragraph 3 below, when This Plan and another plan cover the same child as a dependent of different persons, called parents:

   a. The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
   b. If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

   However, if the other plan does not have the rule described in a. immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent Child/Separated or Divorced - If two or more plans cover an Insured Person as a Dependent Child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the plan of the parent with custody of the Child;

b. Then, the plan of the spouse of the parent with custody;
c. Finally, the plan of the parent not having custody of the Child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. Joint Custody - If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child shall follow the order of benefit determination rules outlined in Paragraph 2.

5. Active/Inactive Employee - The benefits of a plan which covers an Insured Person as an Employee who is neither laid off nor retired are determined before those of a plan which covers that Insured Person as a laid off or retired Employee. The same would hold true if an Insured Person is a Dependent of a Person covered as a retiree and an Employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule 5 is ignored.

6. Continuation Coverage - If an Insured Person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination:

   a. First, the benefits of a plan covering the Insured Person as an Employee, member or subscriber (or as that Insured Person's Dependent);
   b. Second, the benefits under the continuation coverage.

   If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

7. Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the plan which covered an Employee, member or subscriber longer are

determined before those of the Plan which covered that Insured Person for the shorter term.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Section Applies

This Section applies when This Plan is the Secondary Plan in accordance with the order of benefits determination outlined above. In that event, the benefits of This Plan may be reduced under this Section.

Reduction in this Plan's Benefits

The benefits of This Plan will be reduced when the sum of:

1. The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
2. The benefits that would be payable for the Allowable Expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts are needed to apply these COB rules. We have the right to decide which facts we need. We may get needed facts from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each Person claiming benefits under This Plan must give us any facts needed to pay the claim.

FACILITY OF PAYMENT:

A payment made under another plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY:

If the amount of the payments made by Us is more than We should have paid under this COB provision, We may recover the excess from one or more of:

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Figure 48

PREFERRED PROVIDER PROVISIONS (PPO)

Your Employer has elected this PPO Option.

If you or your Dependent receive Covered Services from a Preferred Provider, the percentage payable will be increased and subject to a deductible as shown in the Schedule of Benefits. However, this will not apply to those covered preventive care services which are always paid at 100%.

A Preferred Provider is a Hospital, Physician, Provider or Other Health Care Practitioner who has contracted with Us for the purpose of reducing health care costs by negotiating fees.

A Non-Preferred Provider is a Hospital, Physician, Provider or Other Health Care Practitioner who has not contracted with Us.

PPO Service Area means the geographical area in which Preferred Providers have contracted with Us are located.

[The following counties are designated as your PPO Service Area:_____
_____]

[The following zip codes are designated as your PPO Service Area:
_____]

[Your PPO Service Area is a 50 mile radius from your principal place of employment.]

[Your PPO Service Area is described in
_____]

A list of Preferred Providers in your PPO Service Area will be given to you at the time your coverage becomes effective. Any changes to this list will be provided to you not less than annually.

2055 PPO

When an Insured Person requires Covered Services which are not available through a Preferred Provider, benefits for Covered Services received from Non-Preferred Providers will be paid as if the Covered Services were received from Preferred Providers.

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, he will be required to transfer to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Insured Person chooses not to transfer, benefits will be payable at the Non-Preferred Provider level.

When services are received from Preferred Providers, benefit payments will be made directly to the Preferred Providers. This will apply regardless of any other provision in the Policy to the contrary.

Figure 49

CHEMICAL DEPENDENCY
BENEFIT WAIVER RIDER

Effective Date: _____
Name: _____

The Policy/Certificate of Insurance is amended on the Effective Date shown above as follows:

WAIVER - EXCLUSION

It is understood and agreed that the above named Insured Person, having undergone alcoholism or substance abuse treatment or counseling within the last three years, has waived all benefits for the treatment of alcoholism and substance abuse.

All other terms, provisions, and conditions of the Policy/Certificate will continue to apply.

2055 CDW

OUTLINES OF COVERAGE

Figure 50

[ABC SMALL EMPLOYER CARRIER]
SMALL EMPLOYER
(Non-PPO)
PREVENTIVE AND PRIMARY CARE BENEFIT PLAN
REQUIRED OUTLINE OF COVERAGE

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

(1) **READ YOUR POLICY CAREFULLY.** This Outline of Coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) The Small Employer Preventive and Primary Care Benefit Plan is designed to provide you with coverage for expenses which you incur for preventive care and necessary treatment and services rendered as a result of a covered Injury or Illness. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

(3) **Benefits**: Except for the preventive care benefits that are provided without Copayment or Deductible the following applies: When the Policy Year Deductible of [$250,$100] per individual has been met, We will pay (unless otherwise noted) 80% of Covered Services until you have paid a Policy Year Copayment Maximum of $1,000 per individual or $3,000 per family. We will then pay 100% of Covered Services incurred during the remainder of the Policy Year. The maximum amount We will pay in a Policy Year is $15,000 per individual. There is no lifetime maximum.

Covered Services are: Inpatient Hospital services for up to five days per Policy Year for daily room and board and general nursing services in an amount equal to the average semi-private room rate; confinement in an intensive care or cardiac care unit (maximum of three times the average semi-private room rate); miscellaneous hospital services and supplies including operating room, recovery room, surgical dressings, casts, splints, trusses, braces, initial artificial limbs or eyes, blood when not replaced and its administration;

2055 OC.PP

Hospital outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility;

Services by Physicians, Providers or Other Health Care Practitioners for diagnosis, treatment and surgery of an Illness or Injury;

Physician services for an operation or the repair of a dislocation or fracture;

Assistant surgeon fee (not to exceed 25% of the primary surgeon's fee);

Anesthesia and its administration;

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 pathologist. (Covered Services include outpatient diagnostic services and outpatient treatment visits. A Policy Year maximum of 40 outpatient treatment visits will be provided for any physical therapy, occupational therapy and/or speech therapy.);

Emergency Care services including inpatient Hospital services, outpatient Hospital services, professional ground or air ambulance services for transportation to nearest Hospital equipped to treat the Illness or Injury;

Physician services for an operation, or the repair of a dislocation or fracture, including the services of an assisting surgeon, anesthesia and its administration; and services for medical care provided by a Physician, Provider or Other Health Care Practitioner;

Diagnostic examinations, lab and x-rays services including imaging services, pathology, radiology, and the related interpretations up to a Policy Year maximum benefit of $5,000;

Maternity-related care, including prenatal, delivery, postnatal care, high-risk pregnancy care, Complications of Pregnancy and the initial well child expenses of a newborn Child;

Home health care services established under a plan of care, approved in writing, and reviewed at least every two months by the attending Physician. The Physician must certify that hospitalization or confinement in a Skilled Nursing Facility would otherwise be required. Covered home health care services are limited to a maximum of 40 visits per Policy Year (A visit by a nurse or therapist will be considered one visit, four hours of home health aide service is considered one visit, and each four hours or portion of that period for additional home health aide service is considered one visit.). The Policy Year limit may be waived if the

waiver will result in less expensive treatment and the Insured Person and the Insured Person's Physician agree to an alternate plan of care. Any benefits paid under this provision is subject to the other policy maximums.

Mental Health Services (including Serious Mental Illness) for outpatient evaluation, crisis intervention, and services for treatment. Benefits will be limited to eligible inpatient Hospital services for up to five days per Policy Year, and outpatient services limited to 40 visits per Policy Year.

Evaluation and treatment for Chemical Dependency limited to eligible inpatient services in a Hospital or a Chemical Dependency Treatment Center for up to five inpatient days per Policy Year and outpatient treatment for a maximum of 40 visits per Policy Year.

Well child care including but not limited to ophthalmologic examination for infants at risk for eye problems, child health supervision services - history; physical examination; developmental assessment; anticipatory guidance; appropriate childhood immunizations (payable at 100% of Reasonable and Customary charges and the deductible is waived); laboratory testing; hearing and vision screening - by or supervised by a Physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter. In addition, Covered Services will include annual vision and hearing testing for any covered child under the age of 19 (payable at 100% of the Reasonable and Customary charges and the Deductible is waived).

Rental or purchase, at Our option, of durable medical equipment, including repaires and necessary maintenance;

Oxygen and the rental of equipment for its administration.

One annual physical examination. Services include history; physical examination; laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening. Eligible Expenses for pap tests, colo-rectal screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible will be waived. Remaining Covered Services included in an annual physical examination will be payable at 80%. In addition, Covered Services will include one annual screening by Low-Dose Mammography for any female insured age 35 and over (payable at 100% of the Reasonable and Customary charge and the Deductible will be waived).

(4) **Exclusions and Limitations**: Benefits will not be payable unless services are Medically Necessary, are not in excess of the Reasonable and Customary charges and are recognized as a Covered Service. Additionally, the Policy does not cover expenses incurred resulting from:

Charges for treatment, services and supplies that are Experimental in nature;

Any charge for services or supplies that is not within the scope of authorized practice of the institution or person rendering the services or supplies;

Any treatment provided by an Immediate Family Member or provided by your Employer.

Any loss, expense or charge resulting from the Insured Person's participation in a riot or inciting a riot;

Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity;

Any act of war, declared or undeclared;

Or during active service in the Armed Forces or auxiliary units;

Injury or Illness arising out of employment for wage or profit;

Reversal of sterilization, or medical care or surgery to change gender;

Elective abortions. A voluntary interruption of a pregnancy is not considered an elective abortion if the life of an Insured Person would be endangered if the fetus were carried to term, the pregnancy is a result of a criminal act such as rape or incest, or there is a diagnosis of a non-viable fetus. Benefits for treatment of complications arising from or as a result of an elective abortion shall be payable on the same basis as any other Illness.

Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under the Policy, to reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn Child. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered Cosmetic Surgery for the purposes of this exclusion;

Any services or supplies provided for reduction of obesity or weight, including surgical procedures;

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

Care received in Veterans Administration hospitals for service connected disabilities;

Services or treatment provided in a government hospital unless the Insured Person is legally required to pay;

Services or treatment for which the Insured Person is not legally required to pay;

Personal items such as TV, admitting kits, cots for family members, and guest meals;

Any dental services or supplies except as necessitated by Accidental Injury. (Services must be provided within 12 months of the Injury.) Injuries caused by chewing or biting down;

Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting (unless otherwise covered under a preventive care benefit);

Charges for prescription drugs or pharmaceuticals except when a covered service provided by a Hospital or Ambulatory Surgical Center or when the Prescription Drug Benefit Rider is attached.

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

Private duty nursing services, except for covered home health care services;

Any service or supply in connection with the diagnosis or treatment of infertility and any form or attempt of artificial fertilization or implantation, including without limitation: artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer;

Any service or supply in connection with any transplant;

Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use;

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;

Transportation, except for local ground ambulance service or air ambulance service for Emergency Care;

Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Policy;

Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service;

Any service or supply in connection with routine foot care in the absence of severe systemic disease;

Any medical social services or vocational counseling;

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

[For Chapter 20 companies only:

Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

[Preexisting Conditions will not be covered for a period of 12 months from the Insured Person's Effective Date of coverage.]

(5) Renewability - This Policy is Guaranteed Renewable for Life. There is a Policy Year Maximum Benefit of $15,000 per Insured Person.

(6) Premium - The premium rates may be changed on a class basis. No premium change may be made on an individual basis. The premium for the policy is $____ monthly. The Policy provides a 31 day Grace Period. [There is a one time Policy fee of $_____].

Figure 51

[Insert to
Preventive and Primary Care Benefit Plan for
Prescription Drug Benefit Rider
Form Number 2055 PDR

BENEFITS:

[Fifty percent (50%)] of the following prescription expenses are paid when dispensed by a licensed pharmacist for use by you or your Dependent, while covered under this rider:

1. Drugs and medicines, which by law, can only be obtained with a Physician's written prescription;

2. Injectable insulin prescribed by a Physician;

3. Formulas necessary for the treatment of Phenylketonuria or other heritable diseases when ordered by a Physician;

4. Oral contraceptives, regardless of their intended use.

Copayment for covered prescription expenses do not help satisfy any Policy Year Copayment Maximum.

Charges for Name Brand drugs will only be covered if there is no generic drug available or if the Physician, Provider or Other Health Care Practitioner specifically prescribes a Name Brand drug for the Insured Person and Generic selection is not permitted.

EXCLUSIONS:

To the extent there is not a conflict, the limitations and exclusions of the Policy apply to this rider. In addition to the limitations and exclusions of the Policy, the following limitations and exclusions apply.

We will not pay benefits for any of the following:

1. Drugs or medications which can be lawfully obtained without a Physician's prescription, except insulin;

2. Any charge incurred for the administration of prescription drugs or injectable insulin by a Physician, Provider or Other Health Care Practitioner;

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3. Drugs and substances which are Experimental;

4. Drugs taken or given while you or your Dependent are confined on an inpatient or outpatient basis in a Hospital, extended care facility, nursing home, or similar institution that has a facility for providing drugs;

5. Refill of a prescription for more than the number of times specified by the Physician; or refill dispensed after one year from the order of the Physician;

6. Any quantity of drugs or medicines dispensed which, when taken according to the direction of the Physician, exceed a 34-day supply or 100 unit dose, whichever is greater;

7. Vitamins, prescription vitamins (except prenatal prescription vitamins), dietary supplements (except for Phenylketonuria or other heritable diseases), cosmetic, health and beauty aids;

8. Charges for drugs in excess of the Reasonable and Customary charges in the area where the drugs are dispensed;

9. Therapeutic devices or appliances including hypodermic needles or syringes, support garments and other non-medical items regardless of their intended use;

10. Rogaine when prescribed for hair loss;

11. Retin-A, except when used to treat acne in persons age 25 and under;

12. Blood and blood plasma;

13. Appetite suppressants or any other drugs prescribed for weight loss;

14. Contraceptive devices, infertility medications, and injectable drugs, except insulin;

15. Biological sera;

16. 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 expense, except Medicaid.

The benefits under this rider will be provided in consideration of the payment of the premium for this rider.

TERMINATION:

This rider will terminate upon the earlier of:

1. The date the Policy terminates; or

2. On the first premium due date following Our receipt of the Insured Person's written request that this rider be terminated.

The premium for this Rider is $_____ monthly.]

Figure 52

[ABC SMALL EMPLOYER CARRIER]
SMALL EMPLOYER
PREVENTIVE AND PRIMARY CARE BENEFIT PLAN
(PPO)
REQUIRED OUTLINE OF COVERAGE

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

(1) **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) The Small Employer Preventive and Primary Care Benefit Plan is designed to provide you with coverage for expenses which you incur for preventive care and necessary treatment and services rendered as a result of a covered Injury or Illness. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

(3) **Benefits Provided**: Except for the preventive care benefits that are provided without Copayment or Deductible the following applies: When the applicable Deductible of per individual has been met, We will pay (unless otherwise noted) 80% of Covered Services. If you are your Dependent receive services from a Preferred Provider, the percentage payable will be increased by [10%] [20%]. A list of preferred providers in your PPO Service Area will be given to you at the time your coverage becomes effective. Any changes to this list will be provided to you not less than annually.

After you have paid a Policy Year Copayment Maximum of $1,000 per individual or $3,000 per family, We will then pay 100% of Covered Services incurred during the remainder of the Policy Year. The maximum amount We will pay in a Policy Year is $15,000 per individual. There is no lifetime maximum.

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Covered Services are: Inpatient Hospital services for up to five days per Policy Year for daily room and board and general nursing services in an amount equal to the average semi-private room rate; confinement in an intensive care or cardiac care unit (maximum of three times the average semi-private room rate); miscellaneous hospital services and supplies including operating room, recovery room, surgical dressings, casts, splints, trusses, braces, initial artificial limbs or eyes, blood when not replaced and its administration;

Hospital outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility;

Services by Physicians, Providers or Other Health Care Practitioners for diagnosis, treatment and surgery of an Illness or Injury;

Physician services for an operation or the repair of a dislocation or fracture;

Assistant surgeon fee (not to exceed 25% of the primary surgeon's fee);

Anesthesia and its administration;

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 pathologist. (Covered Services include outpatient diagnostic services and outpatient treatment visits. A Policy Year maximum of 40 outpatient treatment visits will be provided for any physical therapy, occupational therapy and/or speech therapy.);

Emergency Care services including inpatient Hospital services, outpatient Hospital services, professional ground or air ambulance services for transportation to nearest Hospital equipped to treat the Illness or Injury;

Physician services for an operation, or the repair of a dislocation or fracture, including the services of an assisting surgeon, anesthesia and its administration; and services for medical care provided by a Physician, Provider or Other Health Care Practitioner;

Diagnostic examinations, lab and x-rays services including imaging services, pathology, radiology, and the related interpretations up to a Policy Year maximum benefit of $5,000;

Maternity-related care, including prenatal, delivery, postnatal care, high-risk pregnancy care, Complication of Pregnancy and the initial well child expenses of a newborn Child;

Home health care services established under a plan of care, approved in writing, and reviewed at least every two months by the attending Physician. The Physician must certify that hospitalization or confinement in a Skilled Nursing Facility would otherwise be required. Covered home health care services are limited to a maximum of 40 visits per Policy Year (A visit by a nurse or therapist will be considered one visit, four hours of home health aide service is considered one visit, and each four hours or portion of that period for additional home health aide service is considered one visit.). The Policy Year limit may be waived if the waiver will result in less expensive treatment and the Insured Person and the Insured Person's Physician agree to an alternate plan of care. Any benefits paid under this provision is subject to the other policy maximums.

Mental Health Services (including Serious Mental Illness) for outpatient evaluation, crisis intervention, and services for treatment. Benefits will be limited to eligible inpatient Hospital services for up to five days per Policy Year, and outpatient services limited to 40 visits per Policy Year.

Evaluation and treatment for Chemical Dependency limited to eligible inpatient services in a Hospital or a Chemical Dependency Treatment Center for up to five inpatient days per Policy Year and outpatient treatment for a maximum of 40 visits per Policy Year.

Well child care including but not limited to ophthalmologic examination for infants at risk for eye problems, child health supervision services - history; physical examination; developmental assessment; anticipatory guidance; appropriate childhood immunizations (payable at 100% of Reasonable and Customary charges and the deductible is waived); laboratory testing; hearing and vision screening - by or supervised by a Physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter. In addition, Covered Services will include annual vision and hearing testing for any covered child under the age of 19 (payable at 100% of the Reasonable and Customary charges and the Deductible is waived).

Rental or purchase, at our option, of durable medical equipment, including repairs and necessary maintenance.

Oxygen and the rental of equipment for its administration.

One annual physical examination. Services include history; physical examination; laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening. Eligible Expenses for pap tests, colo-rectal screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible will be waived. Remaining Covered Services included in an annual physical examination will be payable at 80%. In addition, Covered Services will include one annual screening

by Low-Dose Mammography for any female insured age 35 and over (payable at 100% of the Reasonable and Customary charge and the Deductible will be waived).

(4) **Exclusions and Limitations**: Benefits will not be payable unless services are Medically Necessary, are not in excess of the Reasonable and Customary charges and are recognized as a Covered Service. Additionally, the Policy does not cover expenses incurred resulting from:

Charges for treatment, services and supplies that are Experimental in nature;

Any charge for services or supplies that is not within the scope of authorized practice of the institution or person rendering the services or supplies;

Any treatment provided by an Immediate Family Member or provided by your employer.

Any loss, expense or charge resulting from the Insured Person's participation in a riot or inciting a riot;

Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity;

Any act of war, declared or undeclared;

Or during active service in the Armed Forces or auxiliary units;

Injury or Illness arising out of employment for wage or profit;

Reversal of sterilization, or medical care or surgery to change gender;

Elective abortions. A voluntary interruption of a pregnancy is not considered an elective abortion if the life of an Insured Person would be endangered if the fetus were carried to term, the pregnancy is a result of a criminal act such as rape or incest, or there is a diagnosis of a non-viable fetus. Benefits for treatment of complications arising from or as a result of an elective abortion shall be payable on the same basis as any other Illness.

Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under the Policy, to reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn Child. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered Cosmetic Surgery for the purposes of this exclusion;

Any services or supplies provided for reduction of obesity or weight, including surgical procedures;

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

Care received in Veterans Administration hospitals for service connected disabilities;

Services or treatment provided in a government hospital unless the Insured Person is legally required to pay;

Services or treatment for which the Insured Person is not legally required to pay;

Personal items such as TV, admitting kits, cots for family members, and guest meals;

Any dental services or supplies except as necessitated by Accidental Injury. (Services must be provided within 12 months of the Injury.) Injuries caused by chewing or biting down;

Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting (unless otherwise covered under a preventive care benefit);

Charges for prescription drugs or pharmaceuticals except when a covered service provided by a Hospital or Ambulatory Surgical Center or when the Prescription Drug Benefit Rider is attached.

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

Private duty nursing services, except for covered Home Health Care services;

Any service or supply in connection with the diagnosis or treatment of infertility and any form or attempt of artificial fertilization or implantation, including without limitation: artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer;

Any service or supply in connection with any transplant;

Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use;

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;

Transportation, except for local ground ambulance service or air ambulance service for Emergency Care;

Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Policy;

Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service;

Any service or supply in connection with routine foot care in the absence of severe systemic disease;

Any medical social services or vocational counseling;

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

[For Chapter 20 companies only:

Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

[Preexisting Conditions will not be covered for a period of 12 months from the Insured Person's Effective Date of coverage.]

(5) Renewability - This Policy is Guaranteed Renewable for Life. There is a Policy Year Maximum Benefit of $15,000 per Insured Person.

(6) Premium - The premium rates may be changed on a class basis. No premium change may be made on an individual basis. The premium for the policy is $____ monthly. The Policy provides a 31 day Grace Period. [There is a one time Policy fee of $_____].

Figure 53

[ABC SMALL EMPLOYER CARRIER]
INDIVIDUAL SMALL EMPLOYER HEALTH
IN-HOSPITAL BENEFIT PLAN
(NON-PPO)
REQUIRED OUTLINE OF COVERAGE

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

(1) **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) The Small Employer In-Hospital Benefit Plan is designed to provide you with coverage for Hospital expenses and follow-up care which you incur for necessary treatment and services rendered as a result of a covered Injury or Illness. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

(3) Benefits: When the Hospital Deductible Per One Period of Hospital Confinement of [$100, $250] per individual has been met, we will pay (unless otherwise noted) 80% of Covered Services. After you have paid a Policy Year Copayment Maximum of [$2,000 $5,000] per individual, We will then pay 100% of Covered Services incurred during the remainder of the Policy Year. The maximum amount We will pay in a Policy Year is $100,000 per individual. The maximum amount We will pay in a lifetime is $1,000,000.

Covered Services are:

Hospital room and board (based on average semi-private room);

Intensive care unit/cardiac unit (three times the average semi-private room rate),

General nursing services;

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Miscellaneous Hospital services and supplies including, but not limited to, operating room, recovery room, surgical dressings, casts, splints, trusses, braces, initial artificial limbs or eyes, rehabilitative services, and blood when not replaced and its administration;

Diagnostic x-ray and laboratory tests and the interpretation thereof;

Services made by Physicians, Providers and other Health Care Practitioners for diagnosis, treatment. rehabilitative services, and surgery;

Assistant surgeon's fees (not to exceed 25% of the primary surgeon's fee);

Anesthesia and its administration;

Mental illness and Chemical Dependency while confined in a Hospital (limited to 50% of covered hospital services);

Outpatient care necessary for recovery due to an inpatient Hospital stay (limited to eligible expense received within 90 days of discharge from the Hospital) including oxygen and the rental of equipment for its administration and rental or at our option, purchase of durable medical equipment, including repairs and necessary maintenance.

(4) **Limitations/Exclusions**: Benefits will not be payble unless services are Medically Necessary, not in excess of the Reasonable and Customary charge and are Covered Services. Additionally, the Policy does not cover expenses incurred resulting from:

Charges for treatment, services and supplies that are Experimental in nature;

Any charge for services or supplies that is not within the scope of authorized practice of the institution or person rendering the services or supplies;

Reversal of sterilization, or medical care or surgery to change gender;

Elective abortions. A voluntary interruption of a pregnancy is not considered an elective abortion if the life of an Insured Woman would be endangered if the fetus were carried to term, the pregnancy is a result of a criminal act such as rape or incest, or there is a diagnosis of a non-viable fetus. Benefits for treatment of complications arising from or as a result of an elective abortion shall be payable on the same basis as any other Illness.

Any loss, expense or charge resulting from the Insured Person's participation in a riot or inciting a riot;

Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity;

Any treatment provided by an Immediate Family Member (you, your spouse, your parent, brother or sister) or provided by the Employer.

Any act of war, declared or undeclared;

Service in the Armed Forces or auxiliary units;

Injury or Illness arising out of, employment for wage or profit;

Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under the Policy, to reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn Child. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered a Cosmetic Surgery for purposes of this Exclusion;

Any services or supplies provided for reduction of obesity or weight, including surgical procedures;

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

Care received in Veterans Administration hospitals for service connected disabilities;

Services or treatment provided in a government hospital unless there is a requirement to pay for these services in the absence of insurance; except 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;

Services or treatment for which the Insured Person is not legally required to pay;

Personal items such as TV, admitting kits, cots for family members, and guest meals;

Any dental services or supplies except as necessitated by Accidental Injury. Services must be provided within 12 months of the date of Injury. Injuries caused by chewing or biting down are excluded;

Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting;

Charges for prescription drugs or pharmaceuticals except when provided as an inpatient in a Hospital;

Any service or supply associated with an autopsy or postmortem examination unless requested by the Insurer;

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

Any service or supply in connection with any transplant;

Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use;

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;

Transportation including ambulance services;

Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Policy;

Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service;

Any service or supply in connection with routine foot care in the absence of severe systemic disease;

Any medical social services, or vocational counseling;

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

[Preexisting conditions will not be covered for a period of 12 months from the Insured Person's effective date of coverage.]

[For Chapter 20 companies only:

Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

(5) Renewability - This Policy is Guaranteed Renewable for Life subject to the Lifetime Maximum Benefit amount. The Lifetime Maximum Benefit is $1,000,000 per Insured Person. There is also a Policy Year Maximum Benefit of $100,000 per Insured Person.

(6) Premium - The premium rates may be changed on a class basis. No premium change may be made on an individual basis. The premium for the Policy is $____ monthly. The Policy provides a 31 day Grace Period. [There is a one time Policy fee of $ _____.]

Figure 54

Insert page for
In-Hospital Benefit Plan Outline of Coverage
when the optional
Supplementary Accidental Injury Benefit Rider is selected.

Supplementary Accidental Injury Benefit Rider
Form Number 2055 ACCR

Benefits: A Supplementary Accidental Injury Benefit will be provided if:

1. an Insured Person has an Accidental Injury while covered under the Policy; and
2. the Covered Services are incurred within 90 days from the date of the Accidental Injury.

Benefits provided are the Reasonable and Customary charges for the necessary care and treatment of the Injury, not to exceed the Supplementary Accidental Injury Benefit shown in the Schedule of Benefits. Any Eligible Expenses paid under this section will not be considered under any other section of the Policy.

Exclusions: To the extent there is not a conflict, the limitations and exclusions of the Policy apply to this rider. In addition to the limitations and exclusions of the Policy, the following limitations and exclusions apply.

No coverage will be provided for:

1. Expenses incurred as a result of Illness;
2. An Injury occurring before the Insured Person is covered;
3. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly;
4. Any loss due to Accidental Injury resulting from an Insured Person's racing a motorized vehicle, either as a professional or an amateur,
5. An Injury arising out of employment for wage or profit;
6. Accidental Injury resulting from piloting or riding in an aircraft of any type, except as a fare paying passenger on a regularly scheduled flight on a commercial airline;

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7. Any loss sustained due to Accidental Injury as the result of an Insured Person's being intoxicated, or under the influence of any narcotic unless administered on the advice of a Physician;

8. Charges incurred for accidents in which an Insured Person is engaged in sky diving, bungee jumping, parachuting, hang gliding, operating or a passenger on any motor driven All Terrain Vehicle which is being operated primarily for support, racing or exhibition purposes. An All Terrain Vehicle is any motor propelled vehicle primarily designed for use in areas not designed as streets or highways intended for public vehicular traffic.

Termination:

This Rider will terminate upon the earlier of:

1. the date the Policy terminates; or

2. the first premium due date following Our receipt of the Insured Person's written request that this Rider be terminated.

The premium for this Rider is $_____monthly.

Figure 55

Insert page to In-Hospital Benefit Plan
Outline of Coverage
when optional
Preventive and Primary Care Benefit Rider is selected.

Preventive and Primary Care Benefit Rider
Form Number 2055 PPR

Benefits: Except for the preventive care benefits that are provided without Copayment or Deductible the following applies: When the Policy Year Deductible of [$250,$100] per individual has been met, we will pay (unless otherwise noted) 80% of Covered Services until you have paid a Policy Year Copayment Maximum of $1,000 per individual or $3,000 per family. We will then pay 100% of Covered Services incurred during the remainder of the Policy Year. The maximum amount we will pay in a Policy Year is $15,000 per individual. There is no lifetime maximum.

Covered Services are:

Hospital outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility.

Services by Physicians, Providers or Other Health Care Practitioners for diagnosis or treatment of an Illness or Injury in an outpatient clinic or office;

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 pathologist. (Covered Services include outpatient diagnostic services and outpatient treatment visits. A Policy Year Maximum of 40 outpatient treatment visits will be provided for any physical therapy, occupational therapy and/or speech therapy.);

Emergency Care services including outpatient Hospital services; professional ground or air ambulance services for transportation to nearest Hospital equipped to treat the Illness or Injury; Physician services for an operation, or the repair of a dislocation or fracture; including the services of an assisting surgeon; anesthesia and its administration; and services for medical care provided by a Physician, Provider or Other Health Care Practitioner.

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Diagnostic examinations, lab and x-rays services including imaging services, pathology, radiology, and the related interpretations up to a Policy Year maximum benefit of $5,000;

Maternity-related care, including prenatal, delivery, postnatal care, high-risk pregnancy care, Complications of Pregnancy, and the initial well child expenses of a newborn Child;

Home health care services established under a plan of care, approved in writing, and reviewed at least every two months by the attending Physician. The attending Physician must certify that hospitalization or confinement in a skilled facility would otherwise be required. Covered home health care services are limited to a maximum of 40 visits per Policy Year. (A visit by a nurse or therapist will be considered one visit, four hours of home health aide service is considered one visit, and each four hours or portion of that period for additional home health aide service is considered one visit.) The Policy Year limit may be waived if the waiver will result in less expensive treatment and the Insured Person and the Insured Person's Physician agree to an alternate plan of care. Any benefits paid under this provision is subject to the other policy maximums.

Mental health services (including Serious Mental Illness) for outpatient evaluation, crisis intervention, and services for treatment. Benefits will be limited to outpatient services limited to 40 visits per Policy Year.

Evaluation and treatment for Chemical Dependency limited to outpatient treatment for a maximum of 40 visits per Policy Year.

Well child care including but not limited to ophthalmologic examination for infants at risk for eye problems, child health supervision services - history; physical examination; developmental assessment; anticipatory guidance; appropriate Childhood Immunizations (payable at 100% of Reasonable and Customary charges and the Deductible is waived); laboratory testing; hearing and vision screening - by or supervised by a Physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years and annually thereafter. In addition, Covered Services will include annual vision and hearing testing for any covered Child under the age of 19 (payable at 100% of the Reasonable and Customary charges and the Deductible is waived)

Rental or, at our option, purchase of durable medical equipment, including repairs and necessary maintenance.

Oxygen, and the rental of equipment for its administration;

One annual physical examination. Services include history, physical examination laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening. Eligible Expenses for pap tests, colo-rectal

screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible will be waived. Remaining Covered Services included in an annual physical examination will be payable as shown on the Schedule of Benefits. In addition, Covered Services will include one annual screening by Low-Dose Mammography for any female insured age 35 and over. Eligible Expense will be payable at 100% of the Reasonable and Customary charge and the Deductible will be waived.

Exclusions and Limitations:

To the extent there is not a conflict, the exclusions and limitations of the Policy apply to this rider. In addition to the exclusions and limitations of the Policy, the following exclusions and limitations apply:

Charges for prescription drugs or pharmaceuticals except when a Covered Service provided by a Hospital or Ambulatory Surgical Center.

Termination:

This Rider will terminate upon the earlier of:

1. the date the Policy terminates; or

2. the first premium due date following Our receipt of the Insured Person's written request that this Rider be terminated.

The premium for this Rider is $_____ monthly.

Figure 56

[ABC SMALL EMPLOYER CARRIER]
INDIVIDUAL SMALL EMPLOYER HEALTH
IN-HOSPITAL BENEFIT PLAN
PPO PLAN
REQUIRED OUTLINE OF COVERAGE

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

(1) **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) The Small Employer In-Hospital Benefit Plan is designed to provide you with coverage for Hospital expenses and follow-up care which you incur for necessary treatment and services rendered as a result of a covered Injury or Illness. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

(3) Benefits: When the applicable Hospital Deductible Per One Period of Hospital Confinement has been met, we will pay (unless otherwise noted) [80%] [70%] of Covered Services. If you or your Dependents receive services from a Preferred Provider, the percentage payable will be increased by [10%] [20%] [30%]. A list of Preferred Providers in your PPO Service Area will be given to you at the time your coverage becomes effective. Any changes to this list will be provided to you not less than annually. After you have paid a Policy Year Copayment Maximum of [$2,000 $5,000] per individual, We will then pay 100% of Covered Services incurred during the remainder of the Policy Year. The maximum amount We will pay in a Policy Year is $100,000 per individual. The maximum amount We will pay in a lifetime is $1,000,000.

Covered Services are:

Hospital room and board (based on average semi-private room);

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Intensive care unit/cardiac unit (three times the average semi-private room rate),

General nursing services;

Miscellaneous Hospital services and supplies including, but not limited to, operating room, recovery room, surgical dressings, casts, splints, trusses, braces, initial artificial limbs or eyes, rehabilitative services, and blood when not replaced and its administration;

Diagnostic x-ray and laboratory tests and the interpretation thereof;

Services made by Physicians, Providers and other Health Care Practitioners for diagnosis, treatment, rehabilitative services, and surgery;

Assistant surgeon's fees (not to exceed 25% of the primary surgeon's fee);

Anesthesia and its administration;

Mental illness and Chemical Dependency while confined in a Hospital (limited tc 50% of covered hospital services);

Outpatient care necessary for recovery due to an inpatient Hospital stay (limited to eligible expense received within 90 days of discharge from the Hospital) including oxygen and the rental of equipment for its administration and rental or, at our option, purchase of durable medical equipment, including repair and necessary meaintenance.

(4) **Limitations/Exclusions**: Benefits will not be payable unless services are Medically Necessary, not in excess of the Reasonable and Customary charge and are Covered Services. Additionally, the Policy does not cover expenses incurred resulting from:

Charges for treatment, services and supplies that are Experimental in nature;

Any charge for services or supplies that is not within the scope of authorized practice of the institution or person rendering the services or supplies;

Reversal of sterilization, or medical care or surgery to change gender;

Elective abortions. A voluntary interruption of a pregnancy is not considered an elective abortion if the life of an Insured Person would be endangered if the fetus were carried to term, the pregnancy is a result of a criminal act such as rape or incest, or there is a diagnosis of a non-viable fetus. Benefits for treatment of complications arising from or as a result of an elective abortion shall be payable on the same basis as any other Illness;

Any loss, expense or charge resulting from the Insured Person's participation in a riot;

Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity;

Any treatment provided by an Immediate Family Member (you, your spouse, your parent, brother or sister) or provided by the Employer.

Any act of war, declared or undeclared;

Service in the Armed Forces or auxiliary units;

Injury or Illness arising out of, employment for wage or profit;

Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under the Policy, to reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn Child. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered a Cosmetic Surgery for purposes of this Exclusion;

Any services or supplies provided for reduction of obesity or weight, including surgical procedures;

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

Care received in Veterans Administration hospitals for service connected disabilities;

Services or treatment provided in a government hospital unless there is a requirement to pay for these services in the absence of insurance; except 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;

Services or treatment for which the Insured Person is not legally required to pay;

Personal items such as TV, admitting kits, cots for family members, and guest meals;

Any dental services or supplies except as necessitated by Accidental Injury. Services must be provided within 12 months of the date of Injury. Injuries caused by chewing or biting down are excluded;

Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting;

Charges for prescription drugs or pharmaceuticals except when provided as an inpatient in a Hospital;

Any service or supply associated with an autopsy or postmortem examination unless requested by the Insurer;

Any service or supply in connection with the diagnosis or treatment of infertility and any form or attempt of artificial fertilization or inplantation, including artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer;

Any service or supply in connection with any transplant;

Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use;

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;

Transportation including ambulance services;

Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Policy;

Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service;

Any service or supply in connection with routine foot care in the absence of severe systemic disease;

Any medical social services, or vocational counseling;

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

[Preexisting conditions will not be covered for a period of 12 months from the Insured Person's effective date of coverage.]

[For Chapter 20 companies only:

Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

(5) Renewability - This Policy is Guaranteed Renewable for Life subject to the Lifetime Maximum Benefit amount. The Lifetime Maximum Benefit is $1,000,000 per Insured Person. There is also a Policy Year Maximum Benefit of $100,000 per Insured Person.

(6) Premium - The premium rates may be changed on a class basis. No premium change may be made on an individual basis. The premium for the Policy is $____ monthly. The Policy provides a 31 day Grace Period. [There is a one time Policy fee of $ _____.]

Figure 57

Insert page to In-Hospital Benefit Plan
Outline of Coverage
when optional
Preventive and Primary Care Benefit Rider is selected.

Preventive and Primary Care Benefit Rider
PPO
Form Number 2055 PPR

Benefits: Except for the preventive care benefits that are provided without Copayment or Deductible the following applies: When the applicable Deductible per individual has been met, we will pay (unless otherwise noted) 80% of Covered Services. If you or your Dependent receive services from a Preferred Provider, the percentage payable will be increased [10%] [20%]. A list of Preferred Providers in your PPO Service Area will be given to you at the time your coverage becomes effective. Any changes to this list will be provided to you not less than annually.

After you have paid a Policy Year Copayment Maximum of $1,000 per individual or $3,000 per family. We will then pay 100% of Covered Services incurred during the remainder of the Policy Year. The maximum amount we will pay in a Policy Year is $15,000 per individual. There is no lifetime maximum.

Covered Services are:

Hospital outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility.

Services by Physicians, Providers or Other Health Care Practitioners for diagnosis or treatment of an Illness or Injury in an outpatient clinic or office;

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 pathologist. (Covered Services include outpatient diagnostic services and outpatient treatment visits. A Policy Year Maximum of 40 outpatient treatment visits will be provided for any physical therapy, occupational therapy and/or speech therapy.);

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Emergency Care services including outpatient Hospital services; professional ground or air ambulance services for transportation to nearest Hospital equipped to treat the Illness or Injury; Physician services for an operation, or the repair of a dislocation or fracture; including the services of an assisting surgeon; anesthesia and its administration; and services for medical care provided by a Physician, Provider or Other Health Care Practitioner.

Diagnostic examinations, lab and x-rays services including imaging services, pathology, radiology, and the related interpretations up to a Policy Year maximum benefit of $5,000;

Maternity-related care, including prenatal, delivery, postnatal care, high-risk pregnancy care, Complications of Pregnancy, and the initial well child expenses of a newborn Child;

Home health care services established under a plan of care, approved in writing, and reviewed at least every two months by the attending Physician. The attending Physician must certify that hospitalization or confinement in a skilled facility would otherwise be required. Covered home health care services are limited to a maximum of 40 visits per Policy Year. (A visit by a nurse or therapist will be considered one visit, four hours of home health aide service is considered one visit, and each four hours or portion of that period for additional home health aide service is considered one visit.) The Policy Year limit may be waived if the waiver will result in less expensive treatment and the Insured Person and the Insured Person's Physician agree to an alternate plan of care. Any benefits paid under this provision is subject to the other policy maximums.

Mental health services (including Serious Mental Illness) for outpatient evaluation, crisis intervention, and services for treatment. Benefits will be limited to outpatient services limited to 40 visits per Policy Year.

Evaluation and treatment for Chemical Dependency limited to outpatient treatment for a maximum of 40 visits per Policy Year.

Well child care including but not limited to ophthalmologic examination for infants at risk for eye problems, child health supervision services - history; physical examination; developmental assessment; anticipatory guidance; appropriate Childhood Immunizations (payable at 100% of Reasonable and Customary charges and the Deductible is waived); laboratory testing; hearing and vision screening - by or supervised by a Physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years and annually thereafter. In addition, Covered Services will include annual vision and hearing testing for any covered Child under the age of 19 (payable at 100% of the Reasonable and Customary charges and the Deductible is waived)

Rental, or at our option, purchase of durable medical equipment, including repairs and necessary maintenance.

Oxygen, and the rental of equipment for its administration;

One annual physical examination. Services include history, physical examination laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening. Eligible Expenses for pap tests, colo-rectal screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible will be waived. Remaining Covered Services included in an annual physical examination will be payable as shown on the Schedule of Benefits. In addition, Covered Services will include one annual screening by Low-Dose Mammography for any female insured age 35 and over. Eligible Expense will be payable at 100% of the Reasonable and Customary charge and the Deductible will be waived.

Exclusions and Limitations:

To the extent there is not a conflict, the exclusions and limitations of the Policy apply to this rider. In addition to the exclusions and limitations of the Policy, the following exlcusions and limitations apply:

Charges for prescription drugs or pharmaceuticals except when a Covered Service provided by a Hospital or Ambulatory Surgical Center.

Termination:

This Rider will terminate upon the earlier of:

1. the date the Policy terminates; or

2. the first premium due date following Our receipt of the Insured Person's written request that this Rider be terminated.

The premium for this Rider is $_____ monthly.

Figure 58

[ABC SMALL EMPLOYER CARRIER]
SMALL EMPLOYER
STANDARD HEALTH BENEFIT PLAN
(Non-PPO Plan)
REQUIRED OUTLINE OF COVERAGE

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

(1) **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) The Small Employer Standard Health Benefit Plan is designed to provide you with coverage for expenses you incur for preventive care and for necessary treatment and services rendered as a result of a covered Injury or Illness. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

(3) **Benefits**: Except for the preventive care benefits that are provided without Copayment or Deductible the following applies: When the Policy Year Deductible has been met [$250, $500] , we will pay (unless otherwise noted) the next 80% of Covered Services. After you have paid a Policy Year Copayment Maximum of [$2,000 or $5,000 per individual; $6,000 or $15,000 per family], We will then pay 100% of Covered Services incurred during the remainder of Policy Year. The maximum amount We will pay per individual in a Policy Year is $250,000. The maximum amount We will pay per individual in a lifetime is $1,000,000.

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Covered Services are:

Services by Physicians, Providers or Other Health Care Practitioners for diagnosis, treatment, and surgery;

Daily Hospital room, board and general nursing services equal to the average semi-private room rate;

Confinement in an intensive care or cardiac care unit to a maximum of three times the average semi-private room rate;

Miscellaneous hospital services and supplies including, but not limited to operating room, recovery room, surgical dressings, casts, splints, trusses, braces, and initial artificial limbs or eyes, blood when not replaced and its administration;

Anesthesia and its administration;

Assistant surgery fee (not to exceed 25% of the primary surgeon's fee for any one assistant);

Professional ground or air ambulance services for transportation to the nearest hospital equipped to treat the Injury or Illness as needed for Emergency Care

Outpatient services made by a Hospital or other emergency care facility for Emergency Care;

Surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility;

Oxygen and the rental of equipment for its administration;

Rental or, at our option, purchase of durable medical equipment, including repair and necessary maintenance;

Inpatient and outpatient radiation therapy, inhalation therapy, and chemotherapy;

Inpatient and outpatient X-ray and laboratory services, including imaging services, pathology, radiology, and the interpretation thereof;

Services for the necessary care and treatment of Chemical Dependency, payable on the same basis as any other Illness. Necessary care or treatment in a Chemical Dependency Treatment Center will be considered as if it were care or treatment in a Hospital. [However, coverage for Chemical Dependency is limited to a Lifetime Maximum of three separate series of treatment for each

Insured Person.];

Maternity related care, including prenatal, delivery, and postnatal care, high risk pregnancy care, and Complications of Pregnancy and the initial well child expenses of a newborn Child;

Well child care including but not limited to ophthalmologic examination for infants at risk for eye problems; child health supervision services -- history, physical examination; developmental assessment; anticipatory guidance; appropriate childhood immunizations (payable at 100% of Reasonable and Customary charges and the Deductible is waived); laboratory testing; hearing and vision screening -- by, or supervised by, a Physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter. In addition, Covered Services will include annual vision and hearing testing for any covered Child under the age of 19 (payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment are waived);

One annual physical examination. Services include history; physical examination; laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening. Eligible Expenses for pap tests, colo-rectal screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment are waived. Remaining covered services included in an annual physical examination will be payable at 80%. In addition, Covered Services will include one Low-dose Mammography for any female insured age 35 and over (payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment are waived).

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 pathologist, subject to a maximum benefit of $10,000 per Policy Year;

Services for only the following tissue transplants and replacements: cornea, prosthetic tissue and joints, vein or artery graft, heart valve, and plantable prosthetic lens in connection with cataracts;

Room, board, and other services in a Skilled Nursing Facility (limited to maximum of $10,000 per Policy Year) provided the confinement is certified by a Physician as necessary for recovery from an Illness or Injury and in lieu of Hospital confinement;

Hospice care provided by a licensed Hospice Care Facility (Maximum Lifetime benefit of $10,000) limited to 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;

Inpatient and outpatient mental health services. Covered expenses include:

1. inpatient mental health services (limited to a maximum of 90 days per Policy Year);
2. 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 shall be determined as if necessary care and treatment in a Psychiatric Day Treatment Facility were inpatient care and treatment in a Hospital, and each full day of treatment in a Psychiatric Day Treatment Facility shall be considered equal to one-half of one day of treatment of mental or emotional illness or disorder in a Hospital for the purposes of determining benefit maximums. An attending Physician must certify that such treatment is in lieu of hospitalization;
3. Treatment in a Crisis Stabilization Unit or a Residential Treatment Center for Children and Adolescents. Benefits are payable only if the mental illness substantially impairs thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a Hospital. Each two days of treatment in a Crisis Stabilization Unit or a Residential Treatment Center for Children and Adolescents will be considered equal to one day of treatment in a Hospital;
4. Outpatient mental health services, limited to a maximum of 40 outpatient visits per Policy Year, subject to a maximum benefit of $100 for each visit.

Treatment of Serious Mental Illness, including inpatient and outpatient evaluation, crisis intervention and services for treatment (paid as any other Illness). Services for treatment in a Psychiatric Day Treatment Facility, Crisis Stabilization Unit or in a Residential Treatment Center for Children and Adolescents are paid as described in parts 2 and 3 of the preceding provision, but will not be limited by number of days.

Home health services under a plan of care established, approved in writing, and reviewed at least every 2 months by the attending Physician and certified by the attending Physician that hospitalization or confinement in a skilled facility would otherwise be required. Covered charges are subject to a maximum limit of $10,000 per Policy Year. The Policy Year limit may be waived if the waiver will result in less expensive treatment and the Insured Person and the Insured

Person's Physician agree to an alternate plan of care. Any benefits paid under this provision will continue to be subject to the other maximums.

Prescription Drug Benefit:

Fifty percent (50%) of the following prescription expenses are paid when dispensed by a licensed pharmacist for use by you or your Dependent, while covered under this Policy:

1. Drugs and medicines, which by law, can only be obtained with a Physician's written prescription;

2. Injectable insulin prescribed by a Physician;

3. Formulas necessary for the treatment of Phenylketonuria or other heritable diseases when ordered by a Physician;

4. Oral contraceptives when prescribed by a Physician regardless of their intended use.

Charges for Name Brand drugs will only be covered if there is no Generic drug available or if the Physician Provider or other Health Care Practitioner specially prescribes a Name Brand drug.

(4) Exclusions and Limitations: Benefits will not be payable unless services are medically necessary, are not in excess of the Reasonable and Customary charges and are recognized as a covered service. Additionally, this Policy does not cover expenses incurred resulting from:

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

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

Reversal of sterilization, or medical care or surgery to change gender.

Elective abortions. A voluntary interruption of a pregnancy is not considered an elective abortion if the life of an Insured Person would be endangered if the fetus were carried to term, the pregnancy is a result of a criminal act such as rape or incest, or there is a diagnosis of a non-viable fetus. Benefits for treatment of complications arising from or as a result of an elective abortion shall be payable on the same basis as any other Illness.

Any loss, expense or charge resulting from the Insured Person's active participation in a riot or inciting a riot.

Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity.

Any treatment provided by an immediate family member (you your spouse, your parent, brother or sister) or provided by your Employer.

Any act of war, declared or undeclared.

Or during active service in the Armed Forces or auxiliary units.

Injury or Illness or in the course of, employment for wage or profit.

Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under this Policy, reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn child. Surgery performed to treat a mental, emotional or nervous disorder through a change in appearance is considered Cosmetic Surgery for the purposes of this exclusions.

Any services or supplies provided for reduction of obesity or weight, including surgical procedures.

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

Care received in Veterans Administration Hospitals for service connected disabilities.

Services or treatment provided in a government Hospital unless the Insured Person is legally required to pay.

Services or treatment for which the Insured Person is not legally required to pay.

Personal items such as TV, admitting kits, cots for family members, and guest meals.

Any dental services or supplies except as necessitated by Accidental Injury. Injuries caused by chewing or biting down are excluded.

Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting (unless otherwise covered under a preventive care benefit).

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

Private duty nursing services, except for covered Home Health Care services.

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

Any service or supply in connection with any transplant, except as otherwise provided for under Covered Services.

Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use.

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.

Transportation, except for local ground ambulance service or air ambulance service for Emergency Care.

Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Policy.

Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service.

Any service or supply in connection with routine foot care in the absence of severe systemic disease.

Any medical social services, or vocational counseling.

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

Preexisting conditions will not be covered for a period of 12 months from the Insured Person's effective date of coverage.

[For Chapter 20 companies only:

Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

Limitations & Exclusions For Prescription Drug Benefit:

In addition to the Limitations and Exclusions listed above, We will not pay Prescription Drug Benefits for any of the following:

Drugs or medications which can be lawfully obtained without a Physician's prescription, except insulin.

Any charge incurred for the administration of prescription drugs or injectable insulin by a Physician, Provider or other Health Care Practitioner.

Drugs and substances which are Experimental.

Drugs taken or given while you or your Dependent are confined on an inpatient or outpatient basis in a Hospital, extended care facility, nursing home or similar institution that has a facility for providing drugs.

Refill of a prescription for more than the number of times specified by the Physician; or refill dispensed after one year from the order of the Physician.

Any quantity of drugs or medicines dispensed which, when taken according to the direction of the Physician, exceed a 34-day supply or 100 unit dose, whichever is greater.

Vitamins, prescription vitamins (except prenatal prescription vitamins) dietary supplements (except for Phenylketonuria or other heritable diseases), cosmetic, health and beauty aids.

Charges for drugs in excess of the Reasonable and Customary charges in the area where the drugs are dispensed.

Therapeutic devices or appliances including hypodermic needles or syringes, support garments and other non-medical items regardless of their intended use.

Rogaine when prescribed for hair loss

Retin-A, except when used to treat acne in persons age 25 and under.

Blood and blood plasma

Appetite suppressants or any other drugs prescribed for weight loss.

Contraceptive devices, infertility medications, and injectable drugs, except insulin.

Biological sera.

Drugs or medications prescribed for an Injury or Illness arising out of employment.

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 expense, except Medicaid.

(5) Renewability - This Policy is Guaranteed Renewable for Life subject to the payment of the Lifetime Maximum Benefit amount. The Lifetime Maximum Benefit amount is $1,000,000 per Insured Person. There is also a Policy Year Maximum Benefit of $250,000 per Insured Person.

(6) Premiums - The premium rates may be changed on a class basis. No premium change may be made on an individual basis. The premium for the policy is $_____ monthly. The Policy provides a 31 Grace Period.
[There is a one time Policy fee of $_____.

Figure 59

[ABC SMALL EMPLOYER CARRIER]
SMALL EMPLOYER
STANDARD HEALTH BENEFIT PLAN
PPO PLAN
REQUIRED OUTLINE OF COVERAGE

THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE EMPLOYER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE EMPLOYER IS A NON-SUBSCRIBER, THE EMPLOYER LOSES THOSE BENEFITS WHICH WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE EMPLOYER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.

(1) **READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

(2) The Small Employer Standard Health Benefit Plan is designed to provide you with coverage for expenses you incur for preventive care and for necessary treatment and services rendered as a result of a covered Injury or Illness. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

(3) **Benefits**: Except for the preventive care benefits that are provided without Copayment or Deductible the following applies: When the [Policy Year Deductible] [Applicable Deductible] has been met, We will pay (unless otherwise noted) the next [70%] [80%] of Covered Services. If you or your Dependent receive services from a Preferred Provider the percentage payable will be increased by [10%] [20%] [30%]. However, this will not apply to those covered preventative care services always paid at 100%. A list of Preferred Providers in your PPO Service Area will be given to you at the time your coverage becomes effective. Any changes to this list will be provided to you not less than annually. After you have paid a Policy Year Copayment Maximum of [$2,000 or $5,000 per individual; $6,000 or $15,000 per family], We will then pay 100% of Covered Services incurred during the remainder of Policy Year. The maximum amount We will pay per individual in a Policy Year is $250,000. The maximum amount We will pay per individual in a lifetime is $1,000,000.
2055 OCPO.STD

Covered Services are:

Services by Physicians, Providers or Other Health Care Practitioners for diagnosis, treatment, and surgery;

Daily Hospital room, board and general nursing services equal to the average semi-private room rate;

Confinement in an intensive care or cardiac care unit to a maximum of three times the average semi-private room rate;

Miscellaneous hospital services and supplies including, but not limited to operating room, recovery room, surgical dressings, casts, splints, trusses, braces, and initial artificial limbs or eyes, blood when not replaced and its administration;

Anesthesia and its administration;

Assistant surgery fee (not to exceed 25% of the primary surgeon's fee for any one assistant);

Professional ground or air ambulance services for transportation to the nearest hospital equipped to treat the Injury or Illness as needed for Emergency Care

Outpatient services made by a Hospital or other emergency care facility for Emergency Care;

Surgical services and supplies provided by an Ambulatory Surgical Center or Hospital outpatient facility;

Oxygen and the rental of equipment for its administration;

Rental or, at our option, purchase of durable medical equipment, including repair and maintenance;

Inpatient and outpatient radiation therapy, inhalation therapy, and chemotherapy;

Inpatient and outpatient X-ray and laboratory services, including imaging services, pathology, radiology, and the interpretation thereof;

Services for the necessary care and treatment of Chemical Dependency, payable on the same basis as any other Illness. Necessary care or treatment in a Chemical Dependency Treatment Center will be considered as if it were

care or treatment in a Hospital. [However, coverage for Chemical Dependency is limited to a Lifetime Maximum of three separate series of treatment for each Insured Person.];

Maternity related care, including prenatal, delivery, and postnatal care, high risk pregnancy care, and Complications of Pregnancy and the initial well child expenses of a newborn Child

Well child care including but not limited to ophthalmologic examination for infants at risk for eye problems; child health supervision services -- history, physical examination; developmental assessment; anticipatory guidance; appropriate childhood immunizations (payable at 100% of Reasonable and Customary charges and the Deductible is waived); laboratory testing; hearing and vision screening -- by, or supervised by, a Physician at the following intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 18 months, 2 years, and annually thereafter. In addition, Covered Services will include annual vision and hearing testing for any covered Child under the age of 19 (payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment be waived);

One annual physical examination. Services include history; physical examination; laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening. Eligible Expenses for pap tests, colo-rectal screening, and prostate cancer screening will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment are waived. Remaining covered services included in an annual physical examination will be payable at 80%. In addition, Covered Services will include one Low-dose Mammography for any female insured age 35 and over (payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment are waived).

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 pathologist, subject to a maximum benefit of $10,000 per Policy Year;

Services for only the following tissue transplants and replacements: cornea, prosthetic tissue and joints, vein or artery graft, heart valve, and plantable prosthetic lens in connection with cataracts;

Room, board, and other services in a Skilled Nursing Facility (limited to maximum of $10,000 per Policy Year) provided the confinement is certified by a Physician as necessary for recovery from an Illness or Injury and in lieu of Hospital confinement;

Hospice care provided by a licensed Hospice Care Facility (Maximum Lifetime benefit of $10,000) limited to 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;

Inpatient and outpatient mental health services. Covered expenses include:

1. inpatient mental health services (limited to a maximum of 90 days per Policy Year);
2. 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 shall be determined as if necessary care and treatment in a Psychiatric Day Treatment Facility were inpatient care and treatment in a Hospital, and each full day of treatment in a Psychiatric Day Treatment Facility shall be considered equal to one-half of one day of treatment of mental or emotional illness or disorder in a Hospital for the purposes of determining benefit maximums. An attending Physician must certify that such treatment is in lieu of hospitalization;
3. Treatment in a Crisis Stabilization Unit or a Residential Treatment Center for Children and Adolescents. Benefits are payable only if the mental illness substantially impairs thought, perception of reality, emotional process, or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a Hospital. Each two days of treatment in a Crisis Stabilization Unit or a Residential Treatment Center for Children and Adolescents will be considered equal to one day of treatment in a Hospital;
4. Outpatient mental health services, limited to a maximum of 40 outpatient visits per Policy Year, subject to a maximum benefit of $100 for each visit.

Treatment of Serious Mental Illness, including inpatient and outpatient evaluation, crisis intervention and services for treatment (paid as any other Illness). Services for treatment in a Psychiatric Day Treatment Facility, Crisis Stabilization Unit or in a Residential Treatment Center for Children and Adolescents are paid as described in parts 2 and 3 of the preceding provision, but will not be limited by number of days.

Home health services under a plan of care established, approved in writing, and reviewed at least every 2 months by the attending Physician and certified by the attending Physician that hospitalization or confinement in a skilled facility would otherwise be required. Covered charges are subject to a maximum limit of

$10,000 per Policy Year. The Policy Year limit may be waived if the waiver will result in less expensive treatment and the Insured Person and the Insured Person's Physician agree to an alternate plan of care. Any benefits paid under this provision will continue to be subject to the other maximums.

Prescription Drug Benefit:

Fifty percent (50%) of the following prescription expenses are paid when dispensed by a licensed pharmacist for use by you or your Dependent, while covered under this Policy:

1. Drugs and medicines, which by law, can only be obtained with a Physician's written prescription;

2. Injectable insulin prescribed by a Physician;

3. Formulas necessary for the treatment of Phenylketonuria or other heritable diseases when ordered by a Physician;

4. Oral contraceptives when prescribed by a Physician regardless of their intended use.

Charges for Name Brand drugs will only be covered if there is no Generic drug available or if the Physician Provider or other Health Care Practitioner specially prescribes a Name Brand drug.

(4) Exclusions and Limitations: Benefits will not be payable unless services are medically necessary, are not in excess of the Reasonable and Customary charges and are recognized as a covered service. Additionally, this Policy does not cover expenses incurred resulting from:

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

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

Reversal of sterilization, or medical care or surgery to change gender.

Elective abortions. A voluntary interruption of a pregnancy is not considered an elective abortion if the life of an Insured Person would be endangered if the fetus were carried to term, the pregnancy is a result of a criminal act such as rape or incest, or there is a diagnosis of a non-viable fetus. Benefits for treatment of complications arising from or as a result of an elective abortion shall be payable on the same basis as any other Illness.

Any loss, expense or charge resulting from the Insured Person's active participation in a riot or inciting a riot.

Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or felonious activity.

Any treatment provided by an immediate family member (you your spouse, your parent, brother or sister) or provided by your Employer.

Any act of war, declared or undeclared.

Or during active service in the Armed Forces or auxiliary units.

Injury or Illness or in the course of, employment for wage or profit.

Cosmetic Surgery, unless due to an Accidental Injury or Illness occurring while covered under this Policy, reconstructive surgery following covered surgery, or to repair a congenital defect of a newborn child. Surgery performed to treat a mental, emotional or nervous disorder through a change in appearance is considered Cosmetic Surgery for the purposes of this exclusions.

Any services or supplies provided for reduction of obesity or weight, including surgical procedures.

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

Care received in Veterans Administration Hospitals for service connected disabilities.

Services or treatment provided in a government Hospital unless the Insured Person is legally required to pay.

Services or treatment for which the Insured Person is not legally required to pay.

Personal items such as TV, admitting kits, cots for family members, and guest meals.

Any dental services or supplies except as necessitated by Accidental Injury. Injuries caused by chewing or biting down are excluded.

Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting (unless otherwise covered under a preventive care benefit).

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

Private duty nursing services, except for covered Home Health Care services.

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

Any service or supply in connection with any transplant, except as otherwise provided for under Covered Services.

Any arch supports; orthopedic shoes; or support hose; or similar type devices/appliances regardless of intended use.

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.

Transportation, except for local ground ambulance service or air ambulance service for Emergency Care.

Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to Accidental Injury occurring while covered under the Policy.

Any service or supply received by an Insured Person as a result of or in connection with a court order, unless otherwise a Covered Service.

Any service or supply in connection with routine foot care in the absence of severe systemic disease.

Any medical social services, or vocational counseling.

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

[Preexisting conditions will not be covered for a period of 12 months from the Insured Person's effective date of coverage.]

[For Chapter 20 companies only:

Any services or supplies furnished by a Noncontracting Facility, except for treatment of emergencies.

Any services or supplies furnished by a Contracting Facility if that Facility has not been approved by us to provide those services or supplies.]

Limitations & Exclusions For Prescription Drug Benefit:

In addition to the Limitations and Exclusions listed above, We will not pay Prescription Drug Benefits for any of the following:

Drugs or medications which can be lawfully obtained without a Physician's prescription, except insulin.

Any charge incurred for the administration of prescription drugs or injectable insulin by a Physician, Provider or other Health Care Practitioner.

Drugs and substances which are Experimental.

Drugs taken or given while you or your Dependent are confined on an inpatient or outpatient basis in a Hospital, extended care facility, nursing home or similar institution that has a facility for providing drugs.

Refill of a prescription for more than the number of times specified by the Physician; or refill dispensed after one year from the order of the Physician.

Any quantity of drugs or medicines dispensed which, when taken according to the direction of the Physician, exceed a 34-day supply or 100 unit dose, whichever is greater.

Vitamins, prescription vitamins (except prenatal prescription vitamins) dietary supplements (except for Phenylketonuria or other heritable diseases), cosmetic, health and beauty aids.

Charges for drugs in excess of the Reasonable and Customary charges in the area where the drugs are dispensed.

Therapeutic devices or appliances including hypodermic needles or syringes, support garments and other non-medical items regardless of their intended use.

Rogaine when prescribed for hair loss

Retin-A, except when used to treat acne in persons age 25 and under.

Blood and blood plasma

Appetite suppressants or any other drugs prescribed for weight loss.

Contraceptive devices, infertility medications, and injectable drugs, except insulin.

Biological sera.

Drugs or medications prescribed for an Injury or Illness arising out of employment.

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 expense, except Medicaid.

(5) Renewability - This Policy is Guaranteed Renewable for Life subject to the payment of the Lifetime Maximum Benefit amount. The Lifetime Maximum Benefit amount is $1,000,000 per Insured Person. There is also a Policy Year Maximum Benefit of $250,000 per Insured Person.

(6) Premiums - The premium rates may be changed on a class basis. No premium change may be made on an individual basis. The premium for the policy is $____ monthly. The Policy provides a 31 Grace Period.
[There is a one time Policy fee of $_____.]

HMO FORMS

FORM NUMBER	DESCRIPTION
2055 HMO-PP	Small Group Primary and Preventive Benefit Plan. Includes required benefit language for HMOs.
2055 HMO-STAN	Small Group Standard Health Benefit Plan. Includes required benefit language for HMOs.
2055 HMO-CONT	Texas Small Employer Group Health Benefit Plan Contract and Certificate of Coverage. Includes optional standard provision language for HMOs.

SMALL GROUP PRIMARY AND PREVENTIVE BENEFIT PLAN

Contract Year Deductible	**[$0-$250]**
Contract Year Copayment Maximum	**1,000 per Member** **$3,000 per family**
Contract Year Maximum Covered Services	**$15,000**

[A Prescription Drug Benefit Rider may be offered with this Benefit Plan]

COVERED SERVICES AND BENEFITS

You shall be entitled to receive the following services of Physicians and other health care providers including medical, surgical, diagnostic, therapeutic and preventive services, which are generally and customarily provided in the Health Plan Service Area, and which are determined to be Medically Necessary. When you require care by health care providers and facilities other than your Primary Care Physician, then your Primary Care Physician must make a written referral for such care.

Only services that are performed, prescribed, directed or authorized by a Health Plan Physician, and/or referred by a Primary Care Physician, are Covered Services.

Neither Health Plan nor Health Plan Physicians shall have any liability whatsoever for any services sought or received by you from a non-plan physician, provider or facility, except as defined in Emergency Care services herein, unless prior referral authorization arrangements have been made by the Primary Care Physician or Health Plan.

		COPAYMENT
A.	**Preventive Health Services**	
	• Childhood immunizations	**None**
	• Pap Test	**None**
	• Mammography	**None**
	• Colo-rectal screenings	**None**
	• Prostate cancer screenings	**None**
	• Vision and hearing testing for children under the age of nineteen	**None**

- Well child care **[0-20% of Reasonable Charge]**

- Physical examination **[0-20% of Reasonable Charge]**
  One per Member per Contract Year

B. Physician Office Visits. **[0-20% of Reasonable Charge]**
Services are provided for the diagnosis and treatment of illness or injury when provided in the medical office of the Primary Care Physician or authorized Specialty Physician.

C. Home Health Services. **[0-20% of Reasonable Charge]**
Maximum of 40 visits per Contract Year.
A plan of care, approved in writing, and reviewed at least every two months by the Primary Care Physician and certified by the Primary Care Physician that hospitalization or confinement in a Skilled Nursing Facility would otherwise be required.
Services include:

a. nursing;
b. physical, occupational, speech or respiratory therapy;
c. intravenous therapy;
d. dialysis;
e. service provided by unlicensed personnel under the delegation of a licensed health professional;
f. the furnishing of medical equipment and medical supplies other than drugs and medicine;
e. nutritional counseling.

D. Durable Medical Equipment **[0-20% of Reasonable Charge]**
Rental or purchase at our option of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty or purchase agreement.

E. Hospital Services.

1. Inpatient Services. **[0-20% of Reasonable Charge]**
Limited to five days per Contract Year.

Coverage is provided for the following inpatient services when, arranged or authorized by Your Primary Care Physician:

- Semi-private room and board.
- Drugs, medications, biologicals and their administration,
- Use of operating and delivery rooms and related facilities,
- Anesthesia and oxygen services,
- Care and services in an intensive care unit when Medically Necessary,
- General nursing care,
- Radiation therapy, inhalation therapy and chemotherapy, and
- Administration of blood and blood components.

2. Outpatient Services. **[0-20% of Reasonable Charge]**

Outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Outpatient facility.

F. Laboratory, Diagnostic, and X-ray Services. **[0-20% of Reasonable Charges]**
Limited to $5,000 per Contract Year.

Prescribed laboratory and radiological procedures, services and materials are provided.

G. Maternity-Related Care. **[0-20% of Reasonable Charges]**

Coverage is provided for maternity-related care including prenatal and postnatal care, delivery, and high-risk pregnancy.

H.	**Mental Health Services.** Coverage is provided for outpatient mental health services and treatment for Serious Mental Illness when authorized by your Primary Care Physician.	**[0-20% of Reasonable Charges] Limited to (5) five days of in-patient services and (40) out-patient visits per Contract Year.**
I.	**Rehabilitation Services.** Rehabilitation therapy including occupational therapy, physical therapy, speech and language therapy is provided on an outpatient basis when prescribed by a Participating Provider.	**[0-20% of Reasonable Charges] Limited to forty (40) visits per Contract Year**
J.	**Drug and Alcohol Abuse Services.** Coverage is provided for all services and supplies relating to alcohol and drug abuse services, including detoxification.	**[0-20% of Reasonable Charges] Limited to 5 days of inpatient services and forty (40) outpatient visits per Contract Year.**
K.	**Emergency Care Services.**	**[0-20% of Reasonable Charges]**

- Within The Service Area.

If emergency services are required within the service area, you must notify your Primary Care Physician prior to receiving care. Prior approval is not required for life-threatening emergencies. You should, in the instance of a life-threatening emergency, seek emergency care of life-threatening conditions and then contact your Primary Care Physician, not later than twenty-four hours after services are received.

Charges for any services provided at the emergency room without prior approval of the Primary Care Physician are your responsibility, except where a life-threatening condition is present.

- Outside The Service Area.

Emergency services outside the service area are provided to assist you if you sustain an accidental injury or become ill while temporarily away from the Service Area.

If you require treatment for an accident or sudden onset of an acute medical condition (high fever, vomiting, etc.) while outside the Service Area, medical treatment may be sought without first contacting the Primary Care Physician. Initial treatment only is covered without the Primary Care Physician's approval. You should notify your Primary Care Physician within 24 hours of provision of such treatment, or as soon thereafter as is practical, so that the Primary Care Physician may initiate necessary follow up care.

If you are admitted to the hospital for an emergency condition by a health care provider other than your Primary Care Physician, You or a family member must notify your Primary Care Physician at the earliest time reasonably possible to allow your Primary Care Physician to coordinate any necessary follow up care.

You can use the Appeals Process under Complaint Procedure to resolve a dispute regarding Emergency Care.

Figure 61

SMALL GROUP STANDARD BENEFIT PLAN

Contract Year Deductible	**[$250-$500]**
Contract Year Copayment Maximum	**[$2000-$5000] per Member**
Contract Year Maximum Covered Services	**$250,000 per Member**
Lifetime Maximum Covered Services	**$1,000,000 per Member**

COVERED SERVICES

You shall be entitled to receive the following services of Physicians and other health care providers including medical, surgical, diagnostic, therapeutic and preventive services, which are generally and customarily provided in the Health Plan Service Area, and which are determined to be Medically Necessary. When You require care by health care providers and facilities other than Your Primary Care Physician, then Your Primary Care Physician must make a written referral for such care.

Only services that are performed, prescribed, directed or authorized by a Health Plan Physician, and/or referred by a Primary Care Physician, are Covered Services.

Neither Health Plan nor Health Plan Physicians shall have any liability for any services sought or received by You from a non-plan physician, provider or facility, except as defined in Emergency Care services herein, unless prior referral authorization arrangements have been made by the Primary Care Physician or Health Plan.

		COPAYMENT
A.	**Preventive Health Services.**	
•	Childhood immunizations.	**None**
•	Pap Test.	**None**
•	Mammography.	**None**
•	Colo-rectal screenings.	**None**
•	Prostate cancer screenings.	**None**
•	Vision and hearing testing for children under the age of nineteen.	**None**
•	Well child care from birth.	**[0-20% of Reasonable Charges]**

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- Physical examination per member **[0-20% of Reasonable Charges.] One per Member per Contract Year.**

B. **Physician Office Visits.** **[0-20% of Reasonable Charge]**
Services are provided for the diagnosis and treatment of illness or injury when provided in the medical office of the Primary Care Physician or authorized Specialty Physician.

C. **Home Health Services.** **[0-20% of Reasonable Charge] Limited to a maximum of $10,000 per contract year**
A plan of care, approved in writing, and reviewed at least every two months by the Primary Care Physician and certified by the Primary Care Physician that hospitalization or confinement in a Skilled Nursing Facility would otherwise be required. Services include:

a. nursing;
b. physical, occupational, speech or respiratory therapy;
c. intravenous therapy;
d. dialysis;
e. service provided by unlicensed personnel under the delegation of a licensed health professional;
f. the furnishing of medical equipment and medical supplies other than drugs and medicine;
e. nutritional counseling.

D. **Durable Medical Equipment.** **[0-20% of Reasonable Charge]**
Rental or purchase at our option of durable medical equipment required for therapeutic use, including repairs and necessary maintenance of purchased equipment, not otherwise provided for under a manufacturer's warranty or purchase agreement.

E. Hospice Care Services. **[0-20% of Reasonable Charge]**

Coverage is provided for hospice care and may be rendered in an in-patient facility or on an out-patient basis as determined by Your Plan Physician.

Limited to a Lifetime Maximum of $10,000.

F. Skilled Nursing Facility. **[0-20% of Reasonable Charge]**

Coverage is provided for skilled nursing facilities as determined by Your Primary Care Physician.

Limited to a Maximum of $10,000 per Contract Year.

G. Hospital Services.

1. Inpatient Services. **[0-20% of Reasonable Charge]**

Coverage is provided for the following inpatient services when arranged or authorized by Your Primary Care Physician:

- Semi-private room and board;
- Drugs, medications, biologicals and their administration;
- Use of operating and delivery rooms and related facilities;
- Anesthesia and oxygen services;
- Care and services in an intensive care unit when Medically Necessary
- General nursing care;
- Radiation therapy, inhalation therapy and chemotherapy;
- Administration of blood and blood components.

2. Outpatient Services. **[0-20% of Reasonable Charge]**

Outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Outpatient facility.

H. **Laboratory, Diagnostic, and X-ray Services.** **[0-20% of Reasonable Charge]**
Prescribed laboratory and radiographic procedures, services and materials are provided.

I. **Maternity-Related Care.** **[0-20% of Reasonable Charge]**
Coverage is provided for maternity-related care including prenatal and postnatal care, delivery, and high-risk pregnancy.

J. **Mental Health Services.**

1. **Outpatient Mental Health Services.** **[0-$100 per Visit] Limited to a Maximum of 40 Visits Per Contract Year**

2. **Inpatient Mental Health Services.** **[0-20% of Reasonable Charge]**
Coverage is provided for inpatient diagnostic and therapeutic services, **Limited to a Maximum of (90) ninety inpatient days per Contract Year.**

Psychiatric Day Treatment Facility, Limited to 180 days Crisis Stabilization Unit or Residential per Contract Year Treatment Center for Children and Adolescents.
Two full days of treatment in such a facility equals one day of treatment in a Hospital or inpatient program.

"Crisis Stabilization Unit" means a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structured activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

"Residential treatment center for children and adolescents" means a child-care institution that provides residential care and treatment for emotionally disturbed 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.

"Psychiatric day treatment facility" means a mental health facility which provides treatment for individuals suffering from acute, mental and nervous disorders 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.

3. **Serious Mental Illness.** **[0-20% of Reasonable Charge]**
Coverage is provided for the care, diagnosis and treatment of the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R.
   a. schizophrenia;
   b. paranoid and other psychotic disorders;
   c. bipolar disorders (mixed, manic and depressive);
   d. major depressive disorders (single episode or recurrent); and
   e. schizo-affective disorders (bipolar or depressive).

K. Rehabilitation Services. **[0-20% of Reasonable Charge]**
Rehabilitation therapy including occupational therapy, physical therapy, speech and language therapy is provided on an outpatient basis when prescribed by a Plan Physician.
Limited to a Maximum benefit of $10,000 per Contract Year.

L. Chemical Dependency Services **[0%-20% of Reasonable Charge]**
Chemical dependency services are covered as any physical illness subject to the following conditions:

A series of treatment is a planned, structured, and organized program to promote chemical free status which may include different facilities or modalities and is complete when the covered individual is discharged on medical advice from inpatient detoxification, inpatient rehabilitation or treatment rehabilitation or treatment, partial hospitalization or intensive outpatient care to a series of three levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of 30 days.

M. Emergency Care Services.

- Within The Service Area. **[0%-20% of Reasonable Charge]**

  If emergency services are required within the service area, You must notify Your Primary Care Physician prior to receiving care. Prior approval is not required for life-threatening emergencies. You should, in the instance of a life-threatening emergency, seek Emergency Care of life-threatening conditions and then contact Your Primary Care Physician, not later than (24) twenty-four hours after services are received.

  Charges for any services provided at the emergency room without prior approval of Your Primary Care Physician are Your responsibility, except where a life-threatening condition is present.

- Outside The Service Area.

  Emergency services outside the service area are provided to assist You if You sustain an accidental injury or become ill while temporarily away from the Service Area.

  If you require treatment for an accident or sudden

onset of an acute medical condition (high fever, vomiting, etc.) while outside the Service Area, medical treatment may be sought without first contacting the Primary Care Physician. Initial treatment only is covered without the Primary Care Physician's approval. You should notify your Primary Care Physician within (24) twenty-four hours of provision of such treatment, or as soon thereafter as is practical, so that the Primary Care Physician may initiate necessary follow up care.

If You are admitted to the hospital for an emergency condition by a health care provider other than Your Primary Care Physician, You or a family member must notify the Primary Care Physician at the earliest time reasonably possible to allow Your Primary Care Physician to coordinate any necessary follow up care.

You can use the Appeals Process under Complaint Procedure to resolve a dispute regarding Emergency Care.

N. Prescription Drugs. [0%-20% of Reasonable Charge]

Coverage is provided for injectable insulin and for any prescription drug, biologicals and compounds, prescribed by a Primary Care Physician or authorized Specialist Physician. Prescriptions and refills must be obtained at a participating pharmacy except out of the area emergency prescriptions.

1. Covered prescriptions are limited to a 30-day supply for each prescription or refill. Prescription orders for chronic conditions will be dispensed in 100 unit doses or a 30 day supply per prescription or refill whichever is greater. A 60 day supply of oral contraceptives may be obtained. Prenatal vitamins will be dispensed up to 100 units per prescription or refill.

2. Formulas necessary for the treatment of Phenylketonuria or other Heritable diseases which require a written prescription are covered.

3. Therapeutic devices or appliances including hypodermic needles or syringes, support garments and other non-medical items regardless of their intended use **are not covered.**

4. Drugs which, by law, do not require a prescription **are not covered.**

5. Prescription refills in excess of the number specified by the Physician and any refill dispensed more than one year after the Physician's order **are not covered.**

6. Any medication which is not Medically Necessary **is not covered** including, but not limited to: appetite suppressants,medications used for cosmetic improvement (e.g. Retin A), and hair loss.

7. You will be responsible for the differences in cost between the brand name prescription drug and generic equivalent prescription drug when the Physician permits a generic equivalent drug, but You request the brand name drug.

TEXAS SMALL EMPLOYER GROUP HEALTH BENEFIT PLAN
CONTRACT and CERTIFICATE OF COVERAGE
(Herein called the Contract)

This Small Employer Group Health Benefit Plan Contract and Certificate of Coverage are issued to You and Your Dependents (if any) who have enrolled in the Health Benefit Plan. This Contract, application, forms and any attachments thereto constitute the entire Contract. You and Your Dependents agree to adhere to these provisions for Covered Services by completing the enrollment form, payment of applicable premium and acceptance of this Contract.

issued by

[Name of HMO]
[Address of HMO]
[City & State]
[Telephone Number]
[1-800-Number]

[Form Number]

2055 HMO-CONT
10-14-93

IMPORTANT NOTICE

To obtain information or make a complaint:

You may contact your (title) at (telephone number)

You may call (company)'s toll-free telephone number for information or to make a compalint at

1-XXX-XXX-XXXX

You may also write to (company) at:

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

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning you premium or about a claim you should contact the (agent) (company) (agent or the company) first. It the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: 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:

Puede comunicarse con su (title) al (telephone number)

Usted puede llamar al numero de telefono gratis de (company)'s para informacion o para someter una queja al

1-XXX-XXX-XXXX

Usted tambien puede escribir a (company):
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 do Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX #(512)475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reciamo, deve comunicarse con el (agente) (la compania) (agente o la compania) primero. So no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

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

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II. SCHEDULE OF BENEFITS

I. CONTRACT PROVISIONS

A. DEFINITIONS

Affiliated Employer: A person connected by common ownership with a small employer. The term includes a person that owns a small employer, shares directors with a small employer, or is eligible to file a consolidated tax return with a small employer.

Ambulatory Surgical Center: Means an appropriately licensed institution or facility, either free-standing or as part of a Hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from a twenty-four (24) hour period.

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

Chemical Dependency Treatment Center: A facility that provides a program for the treatment of chemical dependency with a written treatment plan approved and monitored by a physician. The facility is also:

(1) affiliated with a hospital under a contractual agreement with an established system for patient referral; or

(2) accredited as such a facility by the Joint Commission On Accreditation of Healthcare Organizations; or

(3) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or

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

Contract Year: The 365 day period beginning with the effective date of this Contract.

Controlled Substance: A toxic inhalant or a substance as defined in the Health and Safety Code, Chapter 481.

Copayment: The payment required from the Member at the time Covered Services are delivered.

Covered Class: All employees who reside or work in the Service Area and are eligible but not covered under another health benefit plan or an employee welfare benefit plan that is established according to Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et Seq.).

Covered Services: Those Medically Necessary services that are listed in the Covered Services provision of this Contract when provided or authorized by the Member's Primary Care Physician or the Health Plan.

Deductible: The amount shown in the Covered Services Provision. This amount applies to each Member. We will not provide any benefits under this contract to a member until the services they have received equals the deductible amount.

Dependent: A Member of Your family who meets the eligibility requirement of this Contract, who is listed by You on the enrollment application, and for whom the required premium has been paid.

Emergency Care: Emergency services provided after the sudden onset of acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

You can use the appeals process described in the Complaint Procedure to resolve a dispute regarding Emergency Care.

Eligible Employee: An employee who works on a full-time basis and usually works at least 30 hours a week and meets all applicable eligibility requirements of this Contract. This term includes a sole proprietor, a partner, and an Independent Contractor, if the sole proprietor, partner, or Independent Contractor is included as an employee under a health benefit plan of a small employer. <u>The term does not include:</u>

(1) an employee who works on a part-time, temporary, or substitute basis

or

(2) an employee welfare benefit plan that provides health benefits and that is established according to Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.)

Experimental or Investigative: Experimental means the use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated, or the use of any items requiring federal or other government agency approval not granted at the time services were provided.

You can use the Appeals Process under the Complaint Procedure to resolve a dispute regarding Experimental Treatment.

Health Plan: [The Health Maintenance Organization name]

Home Health Agency: An agency or organization that is duly licensed to provide skilled nursing services and other therapeutic services in the home.

Hospital: An acute care, duly licensed institution that is primarily engaged in providing, on an inpatient basis, medical care and treatment for sick and injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of physicians and with 24 hour a day nursing and physician services.

Initial Enrollment Period: A period of time established by Group and Health Plan during which Eligible Employees and their Dependents first become eligible to enroll as Members. It starts on the date of the Member's first initial date of eligibility and ends 30 days later.

Lifetime Maximum: The maximum benefit available under this contract during a Member's lifetime.

Medically Necessary: The Covered Services prescribed by your Physician, Provider, or Other Health Care Practitioner to treat an Injury or Illness and is known to be safe and effective by the majority of practitioners who are licensed to diagnose or treat that injury or Illness. Such services must be:

(1) Performed in the least costly setting available where the services and treatments can be safely and appropriately provided;

(2) Not provided primarily for the convenience of you, your Physician, or the facility providing the service;

(3) Consistent with professionally recognized standards of care with respect to quality, frequency and duration;

(4) Not primarily Educational, Experimental or Investigative; and

(5) Consistent with your symptoms, diagnosis or treatment.

You can use the Appeals Process under Complaints Procedure to resolve a dispute regarding medical necessity.

Member: Any person covered under this Contract.

Open Enrollment Period: A period of time, occurring at least once a year, established by Group and the HMO during which You and Your eligible Dependents may be enrolled as Members.

Out-of-Service-Area: Any location outside Health Plan's Service Area.

Participating Provider: Duly licensed physicians, hospitals, skilled nursing facilities, extended care facilities, home health agencies, alcoholism and drug abuse facilities, health professionals and any other licensed health professionals, facilities or providers who have entered into a written agreement with Health Plan to provide medical, hospital, or other Covered Services to Members.

Physician: Anyone licensed to practice medicine in the state of Texas.

Pre-existing Condition: This refers to a disease or condition

1) for which medical advice, diagnosis, care, or treatment was recommended or received during the six months before the effective date of coverage; or

2) that would have caused an ordinary, prudent person to seek medical advice, diagnosis, care or treatment during the six months before the effective date of coverage.

Primary Care Physician: The participating physician who is responsible for providing, arranging, and coordinating all aspects of a Member's health care.

Reasonable Charges: The usual charge made by a group, entity, or person who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies to persons:

(1) who reside in the same geographical area;
(2) whose Illness or Injury is comparable in nature and severity.

You may provide your own estimate of the Reasonable Charge by surveying providers in your area and request the We reconsider our determination.

You may use the Appeals Process under Complaint Procedure to resolve a dispute regarding Reasonable Charges.

Serious Mental Illness: Means (1) schizophrenia; (2) paranoid and other psychotic disorders; (3) bipolar disorders (mixed, manic and depressive); (4) major depressive disorders (single episode or recurrent); and (5) schizo-affective disorders (bipolar or depressive).

Service Area: [The HMO service area]

Small Employer: A person that is actively engaged in business and that, on at least 50 percent of its working days during the preceding calendar year employed at least three but not more than 50 eligible employees, including the employees of an affiliated employer, the majority of who were employed in this state.

Specialist Physician: A participating physician, other than a Primary Care Physician, under Contract with Health Plan to provide Covered Services upon referral by the Primary Care Physician.

Toxic Inhalant: A volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paint under Section 485.01, Health and Safety Section 485.001, Health and Safety Code.

YOU and YOUR: The Eligible Employee.

Waiting Period: A period of time during which new employees who have enrolled under this contract are not covered. In no case will coverage begin later than ninety (90) days after the date employment begins.

WE, US, or OUR: the Health Plan.

B. WHO IS ELIGIBLE FOR COVERAGE UNDER THIS PLAN?

FOR EMPLOYEE COVERAGE

You are eligible for Employee Coverage if:

- You are in the **Covered Class,** and
- You live or work in the **Service Area**

FOR DEPENDENT COVERAGE

Dependents include:

(1) Your spouse

(2) Unmarried children less than age 19, including:

(a) **a natural born child, an adopted child, a child waiting for adoption, stepchild** or a child who resides with You in a customary parent-child relationship;

(b) **grandchild,** upon payment of premium, who is a Dependent for purposes of federal income taxes.

(c) **a child who is a full-time student under the age of 23 and who is financially dependent on You**. While the student is enrolled in a school outside the service area, he/she will be eligible for emergency services only;

(d) **a child who is disabled** to such an extent as to be Dependent upon You for care or support;

(e) **newborn coverage is provided for 31 days from the date of birth.** Any congenital defect is treated the same as any other illness or injury for which coverage is provided. We do require that You notify Us during the initial thirty-one (31) days after the birth of the child and pay any premium required to continue coverage for the newborn child.

(3) A court has ordered coverage to be provided for a spouse or minor child under a subscriber's plan and a request for enrollment is made within thirty-one (31) days after issuance of the court order.

C. WHEN YOU MAY ENROLL

You may enroll Yourself and Your Dependents in Health Plan during the Initial Enrollment Period, during the Open Enrollment Period or when You meet Your Group's eligibility requirements.

The group must notify Us, in writing of the effective date of enrollments, terminations or changes on a monthly basis.

Late Enrollee

A late enrollee is an Eligible Employee or Dependent who requests enrollment in a small employer's health benefit plan after the expiration of the Initial Enrollment Period. **Initial Enrollment Period** is the defined time frame for enrollment outlined in the above Definitions Section or otherwise in effect at the time of your employment date. The following situations describe the qualifications for a late enrollee.

1. The individual:

(a) was covered under another employer-provided health benefit plan at the time the individual was eligible to enroll;

(b) declines in writing, at the time of the initial eligibility, stating that coverage under another employer-provided health plan was the reason for declining enrollment;

(c) has lost coverage under another employer health benefit plan as a result of the termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and

(d) Requests enrollment within thirty-one (31) days after termination of coverage under another employer health benefit plan.

2. The individual is employed by an employer who offers multiple health plans and the individual elects a different health benefit plan during an Open Enrollment Period.

3. A court has ordered coverage to be provided for a spouse or minor child under a subscriber's plan and a request for enrollment is made within thirty-one (31) days after issuance of the court order.

The transition period for a late enrollee is described below. (*the HMO will choose one of the following to reflect the date a late enrollee is eligible for coverage)*

[A Late Enrollee is eligible for coverage the first day of the policy month following 18 months from the date of application. The date of application shall be the date the application is received by Us. The Preexisting Condition limitation shall be inapplicable to a Late Enrollee.]

[A Late Enrollee is eligible for coverage the first day of the policy month following the receipt of the application by Us. A Late Enrollee is subject to a 12 month Preexisting Condition limitation beginning on the Effective Date of coverage.]

[A Late Enrollee is eligible for coverage the first day of the policy month following six months from the date of application. The date of application shall be the date the application is received by Us. A Late Enrollee is subject to a 12 month Preexisting Condition limitation beginning on the Effective Date of coverage.]

[A Late Enrollee is eligible for coverage the first day of the policy month following 12 months from the date of application.]

D. SELECTING YOUR PRIMARY CARE PHYSICIAN

Each Member shall, at time of enrollment in the Health Plan, select a Primary Care Physician from the Health Plan's published list of physicians.

The member shall look to the selected Primary Care Physician to direct his/her care, and shall accept procedures and/or treatment recommended by the Primary Care Physicians.

E. CHANGING YOUR PRIMARY CARE PHYSICIAN

You may request a change in your Primary Care Physician by submitting a change request form to Health Plan at least thirty (30) days prior to the requested effective date of transfer.

F. WHEN YOU BECOME COVERED

Coverage for You and Your Dependents is effective on the date that We receive a properly completed enrollment application that was submitted to Us during a period when enrollments were permitted, provided that:

1. No services shall be covered until Your effective date of coverage.

2. Coverage for a newly acquired Dependent should take effect on the date the new dependent is born, adopted, or guardianship papers are signed by the court, or married, as the case may be , if;

   (a) we are notified by You of the birth, adoption, or marriage **within 31 days** after the same occurs (newborn children shall automatically have coverage under this Contract from date of birth, except that coverage terminates thirty-one days after birth unless the child is properly enrolled); and

   (b) all applicable premium is paid.

3. Your Dependent shall not be covered under this Contract until You are covered.

G. PREEXISTING CONDITIONS

No Covered Services provided for under this contract that are incurred for treatment of a Preexisting Condition will be covered for a period of 12 months from the Member's effective date of coverage.

The Preexisting Condition limitation shall not apply to a Member who was continuously covered for a minimum of 12 months by a Health Plan that was in effect up to a date not more than 60 days before the effective date of coverage under this Contract.

Credit shall be given for the time the Member was covered under a previous Health Plan if the previous coverage was in effect at any time during the 12 months before the effective date of coverage under this Contract.

H. WHEN DOES COVERAGE END?

Coverage under this Contract shall end

1. For You and Your **Dependents** if there is:

   (a) failure to pay premium or copayment as required by the terms of the Health Plan. Coverage may be terminated after no less than (30) days written notice.

   (b) fraud or material misrepresentation, except as described in the incontestability provision, coverage may be canceled after not less than (15) days written notice.

   (c) fraud in the use of services or facilities, coverage may be canceled after not less than (15) days written notice.

   (d) failure to meet eligibility requirements; coverage may be canceled immediately, subject to continuation of coverage and conversion privilege provisions.

   (e) misconduct detrimental to safe plan operations and the delivery of services coverage may be canceled immediately.

   (f) failure to establish a satisfactory patient-physician relationship if it is shown that the **Health Plan** has, in good faith, provided You or Your **Dependent** with the opportunity to select an alternative plan physician, You are notified in writing at least 30 days in advance that the Health Plan considers the patient-physician relationship to be unsatisfactory and specifies the changes that are necessary in order to avoid termination, and You or Your Dependent has failed to make such changes, coverage may be canceled at the end of the thirty (30) days.

2. For Group in the case of:

   (a) nonpayment of premium, all coverage may be canceled at the end of the grace period as described in Grace Period provision.

(b) fraud or misrepresentation of a material fact on the part of the Group, coverage may be canceled after 15 days written notice.

(c) non-compliance with Health Plan provisions which may include failure of the small employer to maintain status as a small employer.

3. Non-renewal of Group Coverage:

   The Health Plan may non-renew this Contract if the Health Plan elects to non-renew all the Health Plan Contracts issued to small employers in its service area of this state. The employer must receive notice by the 180th day before the date on which coverage terminates.

4. Unless otherwise stated, Notification will be given to You not later than the 30th day before the date on which the non-renewal of coverage is effective.

I. GRACE PERIOD

A Grace Period of thirty-one (31) days will be granted for the payment of any premium, during which time the Contract continues in force. In no event will any Grace Period extend beyond the date the Contract terminates. If You receive Covered Services during a Grace Period granted to the Group for the late payment of premiums, You may be held liable for the cost of those services if after the end of the grace period, payment is not received.

J. CONTINUATION OF HEALTH COVERAGE

If, under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272), any Member has the right to continue coverage under the Health Plan beyond the date it would otherwise terminate. If the provisions of COBRA are inapplicable and the provisions of an applicable state statute grant the Member similar right to continuation of coverage, this Contract shall be deemed to allow continuation of coverage. This continuation of coverage will be to the extent necessary to comply with the provisions of the applicable statute. Contact Your employer for verification of eligibility and procedures to follow.

K. CONVERSION

If the Member is no longer eligible for coverage the member may, within 31 days after termination of coverage under the Contract, make application for a conversion

plan without furnishing evidence of insurability. A conversion plan will be issued in accordance with the terms and conditions in effect at the time of such application for coverage. No conversion plan is available if the Contract terminates for any reason in its entirety or if the member is:

1. terminated from the Contract for reason 1, 2, 3, 5, & 6, under When Coverage Ends, or

2. You no longer live or work in the Service Area.

L. INCONTESTABILITY OF COVERAGE

This provision limits Health Plan's use of Your statements in contesting Your coverage under this Contract. Health Plan issues this coverage based upon statements made by You. The statements are considered to be truthful and are made to the best of Your knowledge and belief. The following rules apply to each statement.

1. The statement will not be used in a contest to void Your coverage or reduce benefits unless:

   (a) it is in a written enrollment application signed by You; and

   (b) a copy of the enrollment application is or has been furnished to You or Your personal representative.

2. The statement will not be used in the contest after Your coverage has been in force for two years.

M. COORDINATION OF BENEFITS

Health Plan is not responsible to pay claims or coordinate benefits for services that are not eligible for coverage under terms of this Contract or authorized by Health Plan according to the terms, conditions, and limitations of this Contract. Health Plan is not responsible to pay claims or coordinate benefits for services that no charge would be made if You did not have coverage.

For the purposes of this section:

"Plan" means any policy or plan of health care or accident coverage which provides health care services or indemnity benefits, including, without limitation, any groups or association, accident or health insurance policies, group subscriber Contracts, plans of self-insurance, prepayment plans or Contracts, federal, state or local governmental programs providing medical benefits or reimbursement of

medical costs, Worker's Compensation, and Employer's Liability Insurance, or similar act or law, but shall not include individual accident, health or Medicaid.

"Primary Responsibility" means the obligation of a Plan to provide its services or benefits first. Any eligible expenses not then covered are to be covered by whichever Plan(s) is (are) not considered to have Primary Responsibility.

1. Determination of Order of Benefits

If any Member is eligible for services or benefits under two or more Plans, the coverage under those Plans will be coordinated so that not more than 100% of any allowable expenses will be paid for, or provided by all such Plans combined, Primary Responsibility for providing these services will be determined in the following order:

(a) The benefits of a Plan which covers the Member on whose expenses claim is based other than as a Dependent shall be determined before the benefits of a Plan which covers such person as a Dependent.

(b) The benefits of a Plan that covers the person on whose expenses claim is based as a Dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year shall be determined before benefits of Plan that covers such person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a Calendar year. If either Plan does not have the provisions of this paragraph regarding Dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions, of this paragraph shall not apply, and the rule set forth in the Plan that does not have the provisions of this paragraph shall determine the order of benefits; except that in the case of a person for whom claim is made as Dependent child:

(i) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody of the child will be determined before the benefits of a Plan which covers the child as a Dependent of the parent without custody.

(ii) when the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the stepparent, and the benefits of a plan which covers that child as a Dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a Dependent of the parent without custody, and

(iii) notwithstanding subparagraphs (i) and (ii) of this paragraph, when the parents are divorced or separated and there is a court decree which would otherwise establish financial responsibility for the medical, dental, or other health care expenses with respect to the child, the benefits of a Plan that covers the child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a Dependent child.

c. When paragraphs (a) and (b) do not establish an order of benefits determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person the shorter period of time, except that:

(i) the benefits of a Plan covering the person on whose expenses claim is based as a laid-off or retired employee or as the Dependent of such person shall be determined after the benefits of any other Plan covering such person as an employee other than as a laid-off or retired employee or a Dependent of such person; and

(ii) if either Plan does not have a provision regarding laid-off or retired employees, and as a result, each Plan determines its benefits after the other, then the provisions of subparagraph (i) of this paragraph do not apply.

2. Health Plan shall be entitled to:

(a) Determine whether and to what extent a Covered Person has indemnity or other coverage for the Covered Services provided under this Contract;

(b) Establish in accordance with (1) through (3) above priorities for determining Primary Responsibility among the Plans obligated to provide health care services or indemnity benefits;

(c) Release to or obtain from any other Plan any information needed to implement this provision; and

(d) Recover the value of Health Services rendered to the Covered Person under this Contract to the extent that such Health Services are actually provided or indemnified by any other Plan.

The order of Primary Responsibility shall not apply when the covered Person is entitled to receive health care services or benefits, or be indemnified for services or benefits (i) under any Worker's Compensation Act or similar law, (ii) under any

Employers' Liability Insurance and (iii) in a Hospital or facility owned, operated or funded by any federal, state or local government, or through any federal, state or local government program(s) providing medical benefits or reimbursement of medical costs, unless statues or regulations governing such programs provide otherwise, in such instances, the Primary Responsibility shall always rest with that Plan(s) person, or agency, providing the health care services or indemnifying the services under (i), (ii), or (iii) above. If a Covered Person is eligible for services or benefits under two or more Plans, persons or agencies listed in (i), (ii), or (iii), Primary Responsibility shall be determined in the order listed above. In no case shall Heaith Plan be required where care is provided in a Hospital or facility owned or operated by any governmental agency to provide coverage beyond what the covered person would have otherwise been required to pay.

N. SUBROGATION

Health Plan will provide services if another person causes You or Your Dependents to become ill or injured. However, You or Your Dependent must reimburse Health Plan for the cost of the services up to the amount recovered from the other person.

You must assign to Health Plan Your right to receive payment for the services Health Plan provides under this Contract. Health Plan may ask You to provide a lien, a document, in which You authorize Health Plan to charge the responsible person or group for Health Plan's cost. Health Plan may file the lien with the person whose act caused the illness or injury, the person's agent, or the court.

Health Plan also has the right to sue in Your name. You must cooperate and assist Health Plan in its efforts to collect payment for services rendered. Also, You must not take any action that would decrease Health Plan's ability to collect money that is due them.

O. COMPLAINT PROCEDURES

If You have a complaint concerning the provision of Covered Services under this Contract, You may direct Your complaint to [name of HMO] at [address of HMO] , [phone number of HMO].

A representative of the Health Plan will contact You and attempt to resolve the complaint to Your satisfaction within fifteen (15) days of receipt of the complaint.

Appeals Process

If You are still dissatisfied, You can submit Your appeal in writing and it will be forwarded to a committee for further review.

Within thirty (30) days of receipt of Your appeal, the committee will notify You of the date and place of the hearing. Testimony, explanation or other information will be received from You, staff persons, administrators, providers or other persons for a fair appraisal of the appeal.

The committee will inform You in writing of their decision within fifteen (15) days of the conclusion of the hearing and of Your right to legal action.

It is also the option of the insured to demand that the dispute be resolved by mediation or binding arbitration. You will not be able to sue Us to resolve the matters submitted to arbitration. You must pay 10% of the cost of arbitration, and we will pay the remainder of the cost.

P. NOTICE OF CLAIMS

You should not have to pay any amount for Covered Services except for the required Copayments. However, if You do pay more than the required Copayment for covered Services, You should file a claim with the Health Plan **within ninety (90)** days from the date such Covered Services were first incurred. If You file a claim **after** the 90 day period, You are required to document why You could not submit the claim within the allotted time. Under no circumstances, will payment be made for claims submitted more than one year after Covered Services were first incurred.

Q. PAYMENT OF CLAIMS

Payment of claims to the Member as described in P. above, will be handled as follows:

1. No later than the fifteenth day after receipt of a claim from a Member the Health Plan will:

   (a) acknowledge receipt of the claim;

   (b) begin any investigation of the claim; and

   (c) request any necessary information, statements or forms from the Member. Additional requests for information may be made during the course of the investigation.

2. No later than the fifteenth day after receipt of all requested items and information, the Health Plan will:

(a) notify the Member of the acceptance or rejection of the claim and the reason if rejected; or

(b) notify the Member that additional time is needed and state the reason.

3. No later than the forty-fifth day after the Member has been notified of the need for additional time to make a decision, Health Plan shall accept or reject the claim.

4. Claims will be paid no later than the fifth day after notification of legal action.

5. No action shall be taken to recover loss under this Contract until sixty (60) days after the claim has been filed according to the requirements of this Contract. Action shall not be taken at all unless it is taken within one (1) year from the time that the claim is required to be filed by this Contract.

R. GENERAL PROVISIONS

1. Amendment

No change in this agreement will be valid unless evidenced by an amendment signed by an officer of Health Plan and attached to this Contract. No agent or other person, except an officer of Health Plan, has the authority to waive any conditions or restrictions of this Contract.

2. Release and Confidentiality of Medical Records

Health Plan agrees to maintain and preserve the confidentiality of any and all medical records of the Member. However, the Member authorizes the release of information, as permitted by law, and access to any and all of Member medical records for purposes reasonably related to the provision of benefits under this Contract, to Health Plan, its agents and employees, Member's Primary Care Physician, participating providers, outside providers of Utilization Review Committee and appropriate governmental agencies.

3. Clerical Error

Clerical error or delays in keeping records for this Contract:

(a) Will not deny coverage that otherwise would have been granted;
(b) Will not continue coverage that otherwise would have terminated; and
(c) May require a change in premium

If any important facts given to the Health Plan about You are not accurate and they affect coverage:

(a) the true facts will be used to decide whether coverage is in force.

(b) any necessary adjustment to the premium will be made.

4. Notice

Worker's Compensation Not Affected

5. Validity

The unenforceability or invalidity of any paragraph of this Contract shall not effect the enforceability or validity of the rest of this Contract.

6. Conformity with State Law.

Any Provision not in conformity with the Texas HMO Act or other applicable laws shall not be rendered invalid but shall be construed and applied as if it were in full compliance with the Texas HMO Act and other applicable laws.

S. EXCLUSIONS

The following are **non-covered** services and supplies:

1. Services not performed, arranged, authorized or approved in advance by Your Primary Care Physician or Health Plan.

2. Services or care incurred while You are not covered.

3. Unless medically necessary, private room accommodations to the extent that the charges for private room accommodations exceed the institution's most common semi-private room charge.

4. Services rendered to You for injuries or diseases to the extent You are covered or required to be covered by a Worker's compensation law. If You enter into a settlement giving up rights to recover past or future medical benefits under a worker's compensation law, this Contract will not cover past or future medical services that are the subject of or related to that settlement. In addition, if You are covered by a worker's compensation program that limits benefits payable to You if other than specified providers are used and You receive care or services from a provider not specified by the program, this Contract will not cover the balance of any cost remaining after the program has paid.

5. Services and supplies to the extent they are covered by any governmental unit, except as required by federal law for veterans in Veteran's Administration or armed forces' facilities for non-service related medical conditions. This Contract will provide coverage on a primary or secondary basis as required by state or federal law.

6. Transportation except for ambulance service in the case of an emergency.

7. Any portion of the cost in excess of the usual and customary charges for an Emergency Care Covered Service received outside of the Service Area.

8. Surgery and any related services intended to improve appearance. Exception: surgery and any related Covered Services necessary to restore bodily function, correct a deformity resulting from disease, trauma or congenital defect in newborns are covered

9. Service and supplies for cosmetic purposes, including restoration of hair and appearance of skin.

10. Wigs or cranial prosthesis.

11. Experimental or Investigational Services: the use of any treatment, procedure, facility, equipment, drug, device or supply not accepted as standard medical treatment of the condition being treated, or the use of any items requiring federal or other government agency approval not granted at the time services were provided.

12. Elective abortions A voluntary interruption of a pregnancy is not considered an elective abortion if the life of the pregnant woman would be endangered if the fetus were carried to term, the pregnancy is a result of a criminal act such as rape or incest, or there is a diagnosis of a non-viable fetus. Benefits for treatment of complications arising from or as a result of an elective abortion shall be payable on the same basis as any other illness.

13. In-vitro fertilization, intra-fallopian transfer treatment and embryo transplants.

14. Sex change operations and reversal of elective sterilization procedures.

15. Dental Services, dental X-rays, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, any dental treatment involved in the treatment of temporomandibular joint (TMJ) pain dysfunction, and hospitalization for extraction of teeth. Exception: Dental services for damage to sound natural teeth resulting from an accident or injury is covered

16. Any services or supplies for diagnosis or treatment for TMJ unless due to accidental injury.

17. The purchase, examination, or fitting of hearing aids or eye glasses or contact lenses.

18. Practitioner, hospital or clinical services related to radial keratotomy, myopic keratomileusis, and any surgery that involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.

19. Services performed by any provider or physician who is a Member of Your immediate family, including any person who normally resides in Your home.

20. Routine foot care such as treatment for corns and calluses and the cutting of toe nails, unless such services are approved as Medically Necessary by the Primary Care Physician or Health Plan.

21. Treatment of weak, strained or flat feet, including orthopedic shoes and other supportive devices.

22. All surgical or invasive procedures intended for the treatment of obesity. Also excluded is the reversal of such procedures unless it is deemed in advance as Medically Necessary by Health Plan.

23. Dietary regimen and treatment for reducing or controlling weight, including obesity treatment and exercise programs.

24. Acupuncture, naturopathy, megavitamins therapy, psycho-surgery and alcohol therapy that is nutritionally based.

25. Personal hygiene and convenience items, such as, but not limited to , air conditioners, humidifiers, or physical fitness equipment.

26. Unless specifically listed herein as a covered service, outpatient prescription drugs when not written or dispensed by a Participating Provider,

27. All over-the counter supplies and medicines.

28. Confinement in a skilled nursing home, convalescent hospital, a facility or that part of a facility which is primarily for:

(a) rest care, convalescent custodial care;
(b) the care of the mentally ill, drug addicts, or alcoholics; or
(c) rehabilitation, training, schooling, or occupational therapy.

29. Orthomolecular therapy, including nutrients, vitamins, and food supplements.

CERTIFICATION FORMS

(SMALL EMPLOYER CARRIER STATUS) CERTIFICATION TO TEXAS DEPARTMENT OF INSURANCE

RELATING TO MARKETING IN THE SMALL EMPLOYER MARKET IN ACCORDANCE WITH 28 TAC CHAPTER 26 AND INSURANCE CODE, CHAPTER 26

Filing is on behalf of:

_____/_____/_____

Insert Name of Health Carrier (Insurance Company or HMO) / Tx. Co. ID # / NAIC #

☐ (1) The health carrier intends to offer, renew, issue and issue for delivery health benefit plans to small employers and therefore will operate in accordance with Insurance Code, Chapter 26 and this chapter, or

☐ (2) The health carrier does not intend to offer, issue or issue for delivery, health benefit plans to small employers; however, the health carrier intends to offer to/renew health benefit plans issued prior to January 1, 1994, and with respect to such business, intends tc comply with Insurance Code, Chapter 26, and this chapter, as applicable; or

☐ (3) The health carrier does not intend to offer, issue or issue for delivery, health benefit plans to small employers in the State of Texas and intends to nonrenew all health benefit plans issued to small employers in Texas.

☐ (4) The health carrier has no health benefit plans, issued to small employers or to employees of a small employer, which are in force on or after September 1, 1993, and the health carrier does not intend to offer, issue or issue for delivery health benefit plans to small employers.

The undersigned certifies that the carrier intends to operate in accordance with this certification unless or until changed in accordance with 28 TAC Section 26.6. If changed, the carrier will promptly (and at least 30 days prior to any change) notify the department of any new election, with a new certification on this form.

_____ _____

Signature and Title of Person Certifying
Chief Executive Officer, Actuary, or Attorney for the named Health Carrier

Date

[Form No.] 2055 Cert SEHC Status

Duo 12/15/93 - [28 TAC Art 26.27 Figure No. 63]

TEXAS DEPARTMENT OF INSURANCE
STATE OF TEXAS

REGULATIONS TO IMPLEMENT THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

Certification Form for Prototype Forms

I hereby certify, on behalf of_____,that
(Name of Insurance Company)
I have reviewed the requirements of the Small Employer Health Insurance Availability Act (Insurance Code, Chapter 26) and the Regulations to Implement the Small Employer Health Insurance Availability Act under HB 2055 (Chapter 26, Texas Administrative Code) and to the best of my knowledge, this certification filing complies with all laws and regulations. This certification filing includes the attached listing of prototype forms, information regarding the market in which the forms will be used, the completed information for variable provisions, any alternate or additional forms and any required documentation to complete this filing.

_____
Signature of Chief Executive Officer

Please type or print the name of person whose signature appears above.

_____

Date_____

Form No. 2055 Cert Prototypes/Mrkt.

The prototype forms checked below will be used with this plan and comply in all respects to the variable requirements of 28 TAC §14. Each alternate form and form number indicated below for the optional prototype forms is enclosed with this filing for review and approval.

GROUP PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

PROTYPE FORM NUMBER	FORM DESCRIPTION	ALTERNATE FORM (Form No.)
☐ 2055 SE.PP	Policy Face Page (Employer)	☐ _____
☐ 2055 MET.PP	Policy Face Page (MET)*	☐ _____
☐ 2055 ASSN.PP	Policy Face Page (Association)*	☐ _____
☐ TOLLFREE	Tollfree Number & Information	☐ _____
☐ 2055 CERT.PP	Certificate Face Page	☐ _____
☐ TOLLFREE	Tollfree Number & Information	☐ _____
☐ 2055 TCG	Table of Contents	☐ _____
☐ 2055 GGP	General Provisions	☐ _____
☐ 2055 GRP	Group Provisions	☐ _____
☐ 2055 SCH.PP	Schedule of Benefits (Non-PPO)	
☐ 2055 SCHPO.PP	Schedule of Benefits (PPO)	
☐ 2055 DEF.PP	Policy Definitions	
☐ 2055 BEN.PP	Benefits Provided	
☐ 2055 ACC	Alternate Cost Containment	☐ _____
☐ 2055 PPO	Preferred Provider Provisions**	
☐ 2055 EXC.PP	Exclusions and Limitations	
☐ 2055 COP	Continuation/ Conversion	
☐ 2055 COB	Coordination of Benefits	
☐ 2055 PDR	Prescription Drug Rider	
☐ 2055 CDW	Chemical Dependency Benefit Waiver Rider	
	Application***	☐ _____

(Continued on back)

*Face pages for multiple employer trust and association groups shall be filed for each group along with all documentation required by 28 TAC §§3.1-3.5.

**Description of service areas (see item #9 on this certification form for information requested for variable provisions) along with sample schedules shall be included with this filing for preferred provider options.

***All application, enrollment and participation agreement forms shall be included with this filing.

The prototype forms checked below will be used with this plan and comply in all respects to the variable requirements of 28 TAC §14. Each alternate form and form number indicated below for the optional prototype forms is enclosed with this filing for review and approval.

GROUP IN-HOSPITAL BENEFIT PLAN

	PROTYPE FORM NUMBER	FORM DESCRIPTION		ALTERNATE FORM (Form No.)
☐	2055 SE.IH	Policy Face Page (Employer)	☐	_____
☐	2055 MET.IH	Policy Face Page (MET)*	☐	_____
☐	2055 ASSN.IH	Policy Face Page (Association)*	☐	_____
☐	TOLLFREE	Tollfree Number & Information	☐	_____
☐	2055 CERT.IH	Certificate Face Page	☐	_____
☐	TOLLFREE	Tollfree Number & Information	☐	_____
☐	2055 TCG	Table of Contents	☐	_____
☐	2055 GGP	General Provisions	☐	_____
☐	2055 GRP	Group Provisions	☐	_____
☐	2055 SCH.IH	Schedule of Benefits (Non-PPO)		
☐	2055 SCHPO.IH	Schedule of Benefits (PPO)		
☐	2055 SCH.PPR	Schedule of Benefits - Preventive & Primary Care Rider (Non-PPO)		
☐	2055 SCHPO.PPR	Schedule of Benefits - Preventive & Primary Care Rider (PPO)		
☐	2055 DEF.IH	Policy Definitions		
☐	2055 BEN.IH	Benefits Provided		
☐	2055 ACC	Alternate Cost Containment	☐	_____
☐	2055 PPO	Preferred Provider Provisions**		
☐	2055 EXC.IH	Exclusions and Limitations		
☐	2055 COP	Continuation/ Conversion		
☐	2055 COB	Coordination of Benefits		
☐	2055 PPR	Preventive and Primary Care Rider		
☐	2055 ACCR	Supplementary Accidental Injury Benefit Rider		
		Application***	☐	_____

(Continued on back)

*Face pages for multiple employer trust and association groups shall be filed for each group along with all documentation required by 28 TAC §§3.1-3.5.

**Description of service areas (see item #9 on this certification form for information requested for variable provisions) along with sample schedules shall be included with this filing for preferred provider options.

***All application, enrollment and participation agreement forms shall be included with this filing.

The prototype forms checked below will be used with this plan and comply in all respects to the variable requirements of 28 TAC §14. Each alternate form and form number indicated below for the optional prototype forms is enclosed with this filing for review and approval.

GROUP STANDARD HEALTH BENEFIT PLAN

PROTYPE FORM NUMBER	FORM DESCRIPTION	ALTERNATE FORM (Form No.)
☐ 2055 SE.STD	Policy Face Page (Employer)	☐ _____
☐ 2055 MET.STD	Policy Face Page (MET)*	☐ _____
☐ 2055 ASSN.STD	Policy Face Page (Association)*	☐ _____
☐ TOLLFREE	Tollfree Number & Information	☐ _____
☐ 2055 CERT.STD	Certificate Face Page	☐ _____
☐ TOLLFREE	Tollfree Number & Information	☐ _____
☐ 2055 TCG	Table of Contents	☐ _____
☐ 2055 GGP	General Provisions	☐ _____
☐ 2055 GRP	Group Provisions	☐ _____
☐ 2055 SCH.STD	Schedule of Benefits (Non-PPO)	
☐ 2055 SCHPO.STD	Schedule of Benefits (PPO)	
☐ 2055 DEF.STD	Policy Definitions	
☐ 2055 BEN.STD	Benefits Provided	
☐ 2055 ACC	Alternate Cost Containment	☐ _____
☐ 2055 PPO	Preferred Provider Provisions**	
☐ 2055 EXC.STD	Exclusions and Limitations	
☐ 2055 COP	Continuation/Conversion	
☐ 2055 COB	Coordination of Benefits	
☐ 2055 CDW	Chemical Dependency Benefit Waiver Rider	
☐ 2055 ACD	Alternate Benefits for Chemical Dependency	
	Riders	☐ _____
	Application***	☐ _____

(Continued on back)

*Face pages for multiple employer trust and association groups shall be filed for each group along with all documentation required by 28 TAC §§3.1-3.5.

**Description of service areas (see item #9 on this certification form for information requested for variable provisions) along with sample schedules shall be included with this filing for preferred provider options.

***All application, enrollment and participation agreement forms shall be included with this filing.

The prototype forms checked below will be used with this plan and comply in all respects to the variable requirements of 28 TAC §14. Each alternate form and form number indicated below for the optional prototype forms is enclosed with this filing for review and approval.

INDIVIDUAL PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

	PROTYPE FORM NUMBER	FORM DESCRIPTION		ALTERNATE FORM (Form No.)
☐	2055 ISE.PP	Policy Face Page	☐	_____
☐	TOLLFREE	Tollfree Number & Information	☐	_____
☐	2055 DP	Individual Data Page	☐	_____
☐	2055 TCI	Table of Contents	☐	_____
☐	2055 IGP	General Provisions	☐	_____
☐	2055 IRP	Individual Provisions	☐	_____
☐	2055 SCH.PP	Schedule of Benefits (Non-PPO)		
☐	2055 SCHPO.PP	Schedule of Benefits (PPO)		
☐	2055 DEF.PP	Policy Definitions		
☐	2055 BEN.PP	Benefits Provided		
☐	2055 ACC	Alternate Cost Containment	☐	_____
☐	2055 PPO	Preferred Provider Provisions**		
☐	2055 EXC.PP	Exclusions and Limitations		
☐	2055 COB	Coordination of Benefits		
☐	2055 PDR	Prescription Drug Rider		
☐	2055 CDW	Chemical Dependency Benefit Waiver Rider		
☐	2055 OC.PP	Outline of Coverage (Non-PPO)	☐	_____
☐	2055 OC.PDR	Insert to the Outline of Coverage (Non-PPO and PPO) for the Prescription Drug Rider	☐	_____
☐	2055 OCPO.PP	Outline of Coverage (PPO)	☐	_____
		Application***	☐	_____

(Continued on back)

**Description of service areas (see item #9 on this certification form for information requested for variable provisions) along with sample schedules shall be included with this filing for preferred provider options.

***All application, enrollment and participation agreement forms shall be included with this filing.

The prototype forms checked below will be used with this plan and comply in all respects to the variable requirements of 28 TAC §14. Each alternate form and form number indicated below for the optional prototype forms is enclosed with this filing for review and approval.

INDIVIDUAL IN-HOSPITAL BENEFIT PLAN

	PROTYPE FORM NUMBER	FORM DESCRIPTION		ALTERNATE FORM (Form No.)
☐	2055 ISE.IH	Policy Face Page	☐	_____
☐	TOLLFREE	Tollfree Number & Information	☐	_____
☐	2055 DP	Individual Data Page	☐	_____
☐	2055 TCI	Table of Contents	☐	_____
☐	2055 IGP	General Provisions	☐	_____
☐	2055 IRP	Individual Provisions	☐	_____
☐	2055 SCH.IH	Schedule of Benefits (Non-PPO)		
☐	2055 SCHPO.IH	Schedule of Benefits (PPO)		
☐	2055 SCH.PPR	Schedule of Benefits - Preventive & Primary Care Rider (Non-PPO)		
☐	2055 SCHPO.PPR	Schedule of Benefits - Preventive & Primary Care Rider (PPO)		
☐	2055 DEF.IH	Policy Definitions		
☐	2055 BEN.IH	Benefits Provided		
☐	2055 ACC	Alternate Cost Containment	☐	_____
☐	2055 PPO	Preferred Provider Provisions**		
☐	2055 EXC.IH	Exclusions and Limitations		
☐	2055 COB	Coordination of Benefits		
☐	2055 PPR	Preventive & Primary Care Rider		
☐	2055 ACCR	Supplementary Accidental Injury Rider		
☐	2055 OC.IH	Outline of Coverage (Non-PPO)	☐	_____
☐	2055 OC.ACCR	Insert to the Outline of Coverage (Non-PPO & PPO) - Supplementary Accidental Injury Rider	☐	_____

(Continued on back)

☐	2055 OC.PPR	Insert to Outline of Coverage (Non-PPO)-Preventive & Primary Care Benefit Rider	☐	_____
☐	OCPO.IH	Outline of Coverage (PPO)	☐	_____
☐	2055 OCPO.PPR	Insert to the Outline of Coverage (PPO) Preventive & Primary Care Rider (PPO)	☐	_____
		Application***	☐	_____

**Description of service areas (see item #9 on this certification form for information requested for variable provisions) along with sample schedules shall be included with this filing for preferred provider options.

***All application, enrollment and participation agreement forms shall be included with this filing.

The prototype forms checked below will be used with this plan and comply in all respects to the variable requirements of 28 TAC §14. Each alternate form and form number indicated below for the optional prototype forms is enclosed with this filing for review and approval.

INDIVIDUAL STANDARD HEALTH BENEFIT PLAN

	PROTYPE FORM NUMBER	FORM DESCRIPTION		ALTERNATE FORM (Form No.)
☐	2055 ISE.STD	Policy Face Page	☐	_____
☐	TOLLFREE	Tollfree Number & Information	☐	_____
☐	2055 DP	Individual Data Page	☐	_____
☐	2055 TCI	Table of Contents	☐	_____
☐	2055 IGP	General Provisions	☐	_____
☐	2055 IRP	Individual Provisions	☐	_____
☐	2055 SCH.STD	Schedule of Benefits (Non-PPO)		
☐	2055 SCHPO.STD	Schedule of Benefits (PPO)		
☐	2055 DEF.STD	Policy Definitions		
☐	2055 BEN.STD	Benefits Provided		
☐	2055 ACC	Alternate Cost Containment	☐	_____
☐	2055 PPO	Preferred Provider Provisions**		
☐	2055 EXC.STD	Exclusions and Limitations		
☐	2055 COB	Coordination of Benefits		
☐	2055 CDW	Chemical Dependency Benefit Waiver Rider		
☐	2055 ACD	Alternate Benefits for Chemical Dependency		
☐	2055 OC.STD	Outline of Coverage (Non-PPO)	☐	_____
☐	2055 OCPO.STD	Outline of Coverage (PPO)	☐	_____
		Riders	☐	_____
		Application***	☐	_____

(Continued on back)

**Description of service areas (see item #9 on this certification form for information requested for variable provisions) along with sample schedules shall be included with this filing for preferred provider options.

***All application, enrollment and participation agreement forms shall be included with this filing.

PLEASE PROVIDE THE FOLLOWING INFORMATION REGARDING THE MARKET IN WHICH THE FORMS WILL BE USED:

_____Small Employer Market Only
_____All Employer Markets
_____Small Employer and Other Markets
Describe Other Markets:_____
_____

PLEASE COMPLETE THE INFORMATION BELOW FOR VARIABLE PROVISIONS OF THE PROTOTYPE FORMS

1. List and describe any provisions added to or deleted from the prototype forms:

_____
_____
_____
_____
_____

2. List and describe any modified or excluded optional provisions:

_____
_____
_____
_____
_____

3. Preexisting Conditions Limitations: ____Yes ____No

4. Grace Period (for Group): _____Yes _____No _____No. of Days

5. Termination for failure of employer to maintain participation requirements (for Group):

_____Yes _____No

6. Termination for failure of employer to maintain status as a small employer (for Group):

_____Yes _____No

7. _____Policy Year (365 day period beginning on Policy Effective Date) or
_____Policy Year (period of one full calendar year).

8. Prescription Drug Card Program: _____Yes _____No
Explain how the prescription drug card program is used (i.e. always and with all plans, offered as an option to the policyholder,etc.)

_____
_____
_____

9. Description of Preferred Provider Service Area:

_____
_____
_____
_____
_____

10. Description of riders to be offered with the Standard Health Benefit Plan.

_____
_____
_____
_____
_____

(GEOGRAPHIC SERVICE AREAS) CERTIFICATION TO TEXAS DEPARTMENT OF INSURANCE ACCORDING TO 28 TAC CHAPTER 26 AND INSURANCE CODE, CHAPTER 26

Filing is on behalf of:

_____/_____/_____

Insert Name of Health Carrier (Insurance Company/HMO) / Tx. Co. ID # / NAIC #

The named health carrier's geographic service areas are defined identified as follows:

☐ By Zipcode (Attachment prepared by carrier should further define/specify); or

☐ By County (Attachment prepared by carrier should further define/specify); or

☐ By Map (Attachment prepared by carrier should further define/specify area).

The undersigned certifies that the carrier intends to operate in accordance with this geographic certification unless or until changed in accordance with 28 TAC Sections 26.6 and 26.20. If changed, the carrier will promptly (and at least 30 days prior to any change) notify the department of any change on this form.

_____ _____

Signature and Title of Person Certifying
Chief Executive Officer, Actuary, or Attorney for the named Health Carrier

Date

[Form No.] 2055 Cert GEOG

Due with Initial Filings & Each March 1st [28 TAC Art. 26.27 - Figure No. 65]

Figure #66

(ANNUAL ACTUARIAL) CERTIFICATION TO TEXAS DEPARTMENT OF INSURANCE

RELATING TO REQUIREMENTS OF 28 TAC CHAPTER 26 AND INSURANCE CODE, CHAPTER 26

ertification is on behalf of:

_____/_____/_____

Insert Name of Small Employer Carrier (Insurance Company or HMO) / Tx. Co. ID # / NAIC #

COMPLIANCE WITH UNDERWRITING AND RATING PROVISIONS

ne undersigned (certifying) actuary certifies that the underwriting and rating methods of the named small employer carrier:

(1) Comply with accepted actuarial principals and practices;

(2) Are uniformly applied to each small employer health benefit plan (as defined in Texas Insurance Code, Chapter 26) covering a small employer (as defined in Texas Insurance Code, Chapter 26); and

(3) Comply with the provisions of Texas Insurance Code, Chapter 26, and 28 TAC Chapter 26.

REVIEW OF FILING(S) AND COMPLIANCE WITH STATUTES AND RULES

ne undersigned (certifying) actuary has reviewed the filing and based upon his/her best knowledge, information, and belief, filed form(s), contract(s), certificate(s), policy(ies), or evidence of coverage(s) complies in all respects with all provisions exas Insurance Code, Chapter 26, and 28 TAC Chapter 26.

DOCUMENTATION FOR RATING METHODOLOGY, RATING PRACTICES AND UNDERWRITING PRACTICES

he named carrier has in its possession or has been provided a complete and detailed description of the applicable rating ethodology, inlcuding but not necessarily limited to, rating practices and renewal underwriting practicies. Such ocumentation includes information that demonstrates that the applicable rating methods and practices are based on ommonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

_____

lualified Actuary (Certifying Actuary)/[Must have MAAA designation]

he named carrier agrees with the statements made by the certifying actuary and certifies that it will maintain at its principal lace of business a complete and detailed description of rating and underwriting practices, along with documentation that emonstrates that rating metods and practices comply with applicable requirements and are in accordance with the certifying ctuarial statement and applicable statutes and rules. The carrier also certifies that such documentation will be available to ne Commissioner upon his/her request.

_____

ef Executive Officer, Actuary or Attorney for the Carrier

Form No.] 2055 Cert Actuarial

Due 3/1 Each Yr. / [28 TAC 26.27 (Rule) Figure # 66]

REPORT TO TEXAS DEPARTMENT OF INSURANCE
(PRIVATE PURCHASING COOPERATIVES) STATEMENT OF AMOUNTS COLLECTED AND EXPENSES INCURRED IN ACCORDANCE WITH 28 TAC SECTION 26.22(B) AND INSURANCE CODE, CHAPTER 26

Filing is on behalf of:

_____

Insert Name of Private Purchasing Cooperative

$_____ _____

Fill-in "Amounts Collected by Cooperative" Specify Calendar Year During Which Amounts Were Collected

$_____ _____

Fill-in "Expenses Incurred by Cooperative" Specify Calendar Year During Which Expenses Were Incurred

I certify that the information provided in this document is true and accurate based upon my best knowledge, information and belief.

_____ _____

Signature and Title of Person Certifying on behalf of the Board of Directors for the Named Cooperative Date

[Form No.] 2055 Cert Coop Due 3/1/EachYr - [28 TAC Art. 26.27 - Figure No. 67] (certcoop.rls)

(GROSS PREMIUMS) CERTIFICATION TO TEXAS DEPARTMENT OF INSURANCE

Figure #68

RELATING TO GROSS PREMIUMS COLLECTED UNDER HEALTH BENEFIT PLANS OF SMALL EMPLOYERS IN ACCORDANCE WITH 28 TAC CHAPTER 26 AND INSURANCE CODE, CHAPTER 26

iling is on behalf of:

_____/_____/_____

Insert Name of Health Carrier (Insurance Company or HMO) / Tx. Co. ID # / NAIC #

_____

pecify Amount of Gross Premium collected by the named health carrier from health benefit lans delivered, issued for delivery or renewed to small employers for the following specified period:

heck the specified period, for which you are reporting, in the following list of reporting periods:)

- ☐ Calendar Year 1992 (report due Nov. 1, 1993)
- ☐ Calendar Year 1993 (report due Nov. 1, 1994)
- ☐ January 1994 - March 1994 (report due April 31, 1994)
- ☐ April 1994 - June 1994 (report due July 31, 1994)
- ☐ October 1994 - December 1994 (report due Jan. 1, 1995)

certify that the information provided in this document is true and accurate based upon my best nowledge, information and belief.

_____ _____

ignature and Title of Person Certifying
hief Executive Officer, Actuary, or Attorney for the named Health Carrier

Date

orm No.] 2055 Cert Gross Prem

[28 TAC Art. 26.20 Figure No. 68] (certgrpr.rts)

(ANNUAL LISTING - EXEMPT FORMS & SEHBPS) CERTIFICATION TO TEXAS DEPARTMENT OF INSURANCE

RELATING TO REQUIREMENTS OF 28 TAC CHAPTER 26 AND INSURANCE CODE, CHAPTER 26

Certification is on behalf of:

_____/_____/_____

Insert Name of Health Carrier (Insurance Company or HMO) / Tx. Co. ID # / NAIC #

The undersigned certifies that the named health carrier has offered and intends to continue offering plans in accordance with this certification unless or until changed in accordance with 28 TAC Sections 26.6 and 26.20. If changed, the named health carrier will promptly (and at least 30 days prior to any change) notify the department of any change (on this form).

Please check the provisions below as applicable.

_____ A. The policy, contract, certificate or evidence of coverage forms listed below (excluded from th definition of "Health benefit plan" under 28 TAC Chapter 26 and Insurance Code, Chapter 26) are offered, delivered, issued for delivery or renewed to or through small employers in Texas by the name health carrier. (list forms by form number/s and include the date of approval or filing, a brief descriptic of the type of coverage, and the policyholder name if other than an employer or employee) (attach separate sheet if necessary)

_____

_____

_____

_____

_____ B. The named health carrier is not offering or marketing to small employers as a health benefit plan the excluded plans described in A above and the carrier is complying with the provisions of Insurance Code, Chapter 26 and 28 TAC Chapter 26 to the extent applicable.

_____ C. The named health carrier is no longer marketing to small employers in Texas the following health benefit plan/s or rider/s previously filed or certified with the Department: (include in the list of plans each form filed for the plan and each rider by form number and include the date of approval or filing, a brief description of the type of coverage provided and the policyholder name if other than the employer or employee) (attach separate sheet if necessary)

_____

_____

_____

_____

[Form No.] 2055 Cert Ann List-Other/SEHBP

(continued on back)

[Due 3/1/EachYr · 28 TAC Art. 26.27 · Figure No. 69]

_ D. The named health carrier no longer wishes to offer the following plans or riders of those listed above and requests that this checked provision serve as a formal withdrawal of the plan/s or rider/s ıe small employer market. (attach separate sheet if necessary)

__ E. The named health carrier plans to market to small employers in Texas the following health ıefit plan/s and rider/s previously filed or certified with the Department (include in the list of plans ;h form filed for the plan and each rider by form number, the date of approval or filing, a brief scription of the type of coverage and the policyholder by name if other than the employer or ɔloyee) (attach separate sheet if necessary)

rtify that the information provided in this document is true and accurate based upon my best wledge, information and belief.

ıature and Title of Person Certifying
ɜf Executive Officer, Actuary, or Attorney for the named Health Carrier

Date

n No.] 2055 Cert Ann List-Other/SEHBP

[Due 3/1/EachYr - 28 TAC Art 26.27 - Figure No 69]

Figure #70

CERTIFICATION TO TEXAS DEPARTMENT OF INSURANCE RELATING TO REQUIREMENTS OF 28 TAC ARTICLE 26.20(g) AND INSURANCE CODE, CHAPTER 26

Certification is on behalf of:

_____/_____/_____

Insert Name of Small Employer Carrier (Insurance Company or HMO) / Tx. Co. ID # / NAIC #

DATA ON SMALL EMPLOYER HEALTH BENEFIT PLANS (INS. CODE, CHAPTER 26, AND 28 TAC CHAPTER 26

[Fill-in the applicable information in the following chart. A Key is attached which further explains each numbered item and information which must be provided.]

ITEM NUMBER RELATING TO NUMBER OF PLANS ISSUED, SMALL EMPLOYERS' COVERAGE, AND LIVES COVERED (REFER TO ATTACHED KEY WHICH DESCRIBES EACH NUMBERED ITEM AND THE INFORMATION REQUESTED FOR EACH NUMERED ITEM)	NUMBER OF SMALL EMPLOYERS	NUMBER OF LIVES COVERED
(1) Health Benefit Plans in previous calendar year	Newly Issued / Renewed _____/_____	Newly Issued / Renewec _____/_____
(2) Various Plans (A) Preventive and Primary Care Benefit Plan (B) In-Hospital Benefit Plan (C) Standard Health Benefit Plan	Newly Issued / Renewed (A)_____/_____ (B)_____/_____ (C)_____/_____	Newly Issued / Renewe (A)_____/_____ (B)_____/_____ (C)_____/_____
(3) Riders (A) Prescription Drug rider with Preventive and Primary Care Benefit Plan; (B) Prevetive and Primary Care Benefit Rider with the In-Hospital Benefit Plan; and/or (C) Other Riders with the Standard Health Benefit Plan.	Newly Issued / Renewed (A)_____/_____ (B)_____/_____ (C)_____/_____	Newly Issued / Renewe (A)_____/_____ (B)_____/_____ (C)_____/_____
(4) Small Employer Health Benefit Plans (List by County or Zipcode or Other (as applicable) and list applicable zipcodes, counties, other; expand space as necessary.)		
(5) Small Employer Health Benefit Plans voluntarily not renewed by small employer (previous calendar year.)		
(6) Small Employer Health Benefit Plans Terminated or Non renewed		
(7) Plans issued to small employers that were uninsured for at least two months prior to issue.)		

[Form No.] 2055 Cert Data Page 1 [Due 3/1/EachYr] - [28 TAC Art. 26 27 - Figure No. 70] (certdata)

KEY FOR NUMBERED ITEMS IN PRECEDING CHART
(REQUIRED UNDER INS. CODE, CHAPTER 26, AND 28 TAC §26.24)

llowing information, related to health benefits plans issued by health carriers to small employers in this state, is required provided no later than March 1 of each calendar year, under 28 TAC Article 26.27:

(1) The number of small employers that were issued and the number of lives covered under health benefit s in the previous calendar year (separated as to newly issued plans and renewals);

(2) The number of small employers that were issued and the number of lives covered under the preventive primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan in the previous calendar year arated as to newly issued plans and renewals and as to class of business);

(3) The number of small employers that were issued and the number of lives covered under a prescription rider with the preventive and primary care benefit plan; a preventive and primary care benefit rider with the in-hospital fit plan; other riders with the standard health benefit plan.

(4) The number of small employer health benefit plans in force and the number of lives covered under plans in each county (or by zip code) of the state as of December 31 of the previous calendar year;

(5) The number of small employer health benefit plans that were voluntarily not renewed by small oyers in the previous calendar year;

(6) The number of small employer health benefit plans that were terminated or non renewed (for reasons than nonpayment of premium) by the health carrier in the previous calendar year; and

(7) The number of small employer health benefit plans that were issued to small employers that were sured for at least the two months prior to issue.

tify that the information provided on the enclosed chart with respect to the named carrier, is true and accurate to the best of nowledge, information and belief.

_____ _____

ature and Title of Person Certifying (on behalf of named carrier) Date
f Executive Officer, Actuary, or Attorney for the named Health Carrier

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