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Withdrawn Sections - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.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

TITLE 28. INSURANCE
Part I. Texas Department of Insurance
Chapter 26. Small Employer Health Insurance Regulations

• **28 TAC §§26.1-26.27**

The State Board of Insurance and the Commissioner of Insurance proposes new §§26.1-26.27 concerning the requirements for complying with the Small Employer Health Insurance Availability Act. Section 26.1 describes the purpose of the sections, §26.2 adopts and incorporates certain forms to be used with small employer health plans, §26.3 contains the severability clause, §26.4 defines the words and terms used in the sections, and §26.5 describes the applicability and scope of these sections and the plans to which these sections are applicable (e.g., by type, purchaser, dates of issue, and the changing status of the employer contributing to the plans). Section 26.6 lists the ways in which a carrier becomes a health carrier as described in these sections, outlines the duties of health carriers in connection with these sections under varying circumstances, and sets out the reporting requirement for health carriers to elect whether or not to be a small employer carrier, and to designate geographic areas. Section 26.7 outlines the requirement that a small employer carrier must offer to provide coverage to entire groups and sets out the ways in which various members of the groups must be treated, as well as the requirements for enrollment periods, and §26.8 sets forth the way in which the contribution and participation requirements for small employer health benefit plans must be determined. Section 26.9 contains requirements and limitations on exclusions, limitations, waiting periods, preexisting conditions and restrictive riders written in connection with small employer health benefit plans. Section 26.10 sets out the requirements for determining the classes of business of small employers for rating purposes. Section 26.11 describes the restrictions relating to premium rates and sets forth the requirements for rating manuals and rating methods, as well as the requirements for subsequent changes in rating methods. Section 26.12 describes the disclosures which must be given by each small employer carrier and each agent as part of any solicitation and distribution of sales materials relating to small employer health benefit plans. Section 26.13 contains the requirements for fair marketing of small employer health benefit plans. Section 26.14 contains the requirements for coverage (the three prescribed plans and the optional plans) which must be offered to small employers; §26. 15 contains the requirements for additional coverage which must be offered under certain circumstances. Section 26.16 contains the requirements for renewability of coverage and the rules relating to limitations on cancellation; §26.17 describes the circumstances under which a small employer may elect to refuse to renew coverage and the fact that the election will foreclose the carrier from writing small employer health benefit plans in the state or geographic area for a period of five years, the way in which a carrier may reapply to reenter the small employer market after the passage of five years, and the requirements that the carrier give notification of termination of coverage; §26.18 describes the contents of the notice to covered persons of the termination of coverage. Section 26.19 describes the requirements for filing policy forms, contracts, certificates and evidences of coverage for health benefit plans in the small employer market, and §26.20 contains the reporting requirements for health carriers subject to Insurance Code, Chapter 26. Section 26.21 contains the requirements for and limitations on cost containment. Section 26.22 sets out the requirements for private purchasing cooperatives and §26.23 contains a description of the powers and duties of the Texas Health Benefits Purchasing Cooperative and private purchasing cooperatives. Section 26.24 lists the procedures for the appeals process in connection with the filing and approval requirements of these sections and the mailing address for the reporting requirements found in these sections. Section 26.25 states that misrepresentations about the effects of Insurance Code, Chapter 26 will be considered a violation of Insurance Code, Articles 21. 20 and 21.21, and §26.26 describes the administrative violations and penalties. The forms are listed in §26.27 of these sections and printed in the appendix which follows that section. Copies of these forms are on file with the Office of the Secretary of State, Texas Register Section. Copies of these forms and complete sets of prototype forms may be obtained from the Texas Department of Insurance, Publications Department, MC 108-5A, P. O. Box 149104, Austin, Texas 78714-9104.

Ms. Myron also has determined that for the first five year period the proposed sections will be in effect, there will be no fiscal implications for local government as a result of enforcing or administering the rule, and there will be no effect on local employment or the local economy. The cost to state government to implement these sections for the first five year period the proposed sections will be in effect, was included in the fiscal note for the underlying statute. There is no anticipated loss or increase in revenue to state or local government as a result of the sections. Based upon the cost per hour of labor, the cost of compliance for small businesses affected by the proposed sections will be the same as the cost of compliance for the largest businesses.

Rhonda Myron, deputy commissioner, life/health, has also determined that for each year of the first five years the proposed sections are in effect, the public benefit anticipated as a result of enforcing the sections is the benefit of increased availability of insurance to employers and employees of small businesses, a standardized claim billing form which will reduce administrative costs, and, if an insurer chooses to issue coverage to a small employer, availability of coverage to all employees not otherwise covered by health benefits, including those with pre-existing illnesses (although a pre-existing condition provision may apply to expenses incurred prior to the first anniversary date of the date of coverage). The anticipated economic cost to the insurers who are required to comply with the proposed sections is $300, 000 to $900,000 annually, for the first year of the first five year period the proposed sections are in effect, and $120,000 to $360,000 annually for each of the remaining years of the first five year period the proposed sections are in effect. The anticipated cost estimates do not include any costs for guaranteed issue as guaranteed issue is not effective until September 1, 1995, and is not covered by these rules. The cost to small employers of their contribution to the insurance is not included as that is the cost of insurance and not the cost of these rules. While these rules cannot compel the employers to provide the requested paperwork to the health carriers seeking to write small employer health benefit plans and they are, therefore, not technically persons required to comply with these rules, the estimated costs for employers to complete the necessary paperwork is included in this note for the sake of completeness. The cost to small employers to complete the paperwork which these rules allow insurers to require from them is anticipated to be $800 to $2500 for each year of the first five years the proposed sections are in effect, depending upon the manner in which the employer gathers the information.

Comments on the proposal, to be considered by the Commissioner and State Board of Insurance, must be submitted in writing within 30 days after publication of the proposed section in the Texas Register, to Linda von Quintus-Dorn, Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment should be submitted to Rhonda Myron, Deputy Commissioner, Life/Health, Mail Code 106-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The only comments which will be considered are those comments made on the proposal published in the Texas Register. Comments provided previously on the initial drafts of these sections will not be considered as comments on the proposed sections. Comments may also be provided at the public hearing which has been scheduled for November 18, 1993, at 9:00 a.m. at the Texas Department of Insurance, Room 100, 333 Guadalupe, Austin. The purpose of this hearing is to afford all interested persons reasonable opportunity to submit data, views or arguments orally or in writing as provided in the Government Code,

§2001.029 (Formerly APTRA, §5C). Final action will not be taken at this time but will be scheduled for a later date.

The new sections are proposed under the Insurance Code, Chapter 26 and Insurance Code, Articles 1.03A, 1.10, 1 33, 21.20, 21.21, 21.21-3, and 21.21-5, and §1.23 of House Bill 1461, 73rd Legislature, Regular Session. Insurance Code, Chapter 26 sets out the requirements for small employer health benefit plans, including but not limited to fair marketing, disclosure, rating, mandated policy provisions, mandates for offering coverage for small employer health carriers, coverage and renewability of the policies, various filing and reporting requirements, cancellation, contribution and participation requirements, exclusions, limitations, pre-existing conditions, previous coverage and status of health carriers as small employer health carriers. These rules are intended to implement the provisions of that chapter. Insurance Code, Article 21.20, prohibits misrepresentation of policies and Article 21.21 contains prohibitions against unfair competition and unfair trade practices and discrimination Article 21.21-3 prohibits discrimination in coverage or rates due to disability and Article 21.21-5 prohibits discrimination in rates or renewals on the grounds of geographical location, disability, sex, or age. These rules are intended to address such discrimination in connection with the coverage which is subject to these sections. Insurance Code, Article 1.03A, sets forth the requirements for rules of general application to be adopted by the commissioner of insurance. Article 1.10 authorizes sanctions for violations by licensees. Article 1.33 sets forth the summary procedures for routine matters. Section 1.23 of House Bill 1461 authorizes the promulgation and approval of rules relating to rates, policy forms and endorsements by the State Board of Insurance.

The following are the statutes that are affected by this rule: Rule Number Statute, Article or Code. Insurance Code, Chapter 26 §26.1; Insurance Code, Chapter 26, §26.2, Insurance Code, Article 3.42, §26 3; Insurance Code, Article 1.33, §26.4; Insurance Code, Chapter 26, §26 5; Insurance Code, Chapter 26, §26.6; Insurance Code, Chapter 26, §26.7; Insurance Code, Chapter 26, and Insurance Code, Articles 3.42, 21.20, 21.21, and 21.21-3, §26.8; Insurance Code, Chapter 26, and Insurance Code, Articles 3.42, 21.20, 21.21 and 21.21-3, §26.9; Insurance Code, Chapter 26, and Insurance Code, Articles 3.42, 21.20, 21.21, and 21.21-3, §26. 10; Insurance Code, Chapter 26, and Insurance Code, Articles 3.42, 21.20, 21. 21, 21.21-3 and 21.21-5, §26.11, Insurance Code, Chapter 26, and Insurance Code, Articles 3.42, 21.20, 21.21, 21.21-3, and 21.21-5, §26.12; Insurance Code, Chapter 26, and Insurance Code, Articles 21 20 and 21.21, §26.13; Insurance Code, Chapter 26, and Insurance Code, Articles 21.20, 21 21, 21.21-3, and 21.21-5, §26.14; Insurance Code, Chapter 26, and Insurance Code, Articles 3.42, 21.20, 21 21, 21.21-3, and 21.21-5, §26.15; Insurance Code, Chapter 26; and Insurance Code, Articles 3 42, 21 20, 21.21, 21.21-3, and 21. 21-5, §26 16; Insurance Code, Chapter 26, and Insurance Code, Articles 3.42, 21.20, 21.21, 21.21-3 and 21.21-5, §26.17; Insurance Code, Chapter 26; and Insurance Code, Articles 3.42, 21.20, 21.21, 21.21-3, and 21.21-5, §26.18; Insurance Code, Chapter 26; and Insurance Code, Articles 21.20, 21.21, 21.21-3, and 21.21-5, §26.19; Insurance Code, Chapter 26; and Insurance Code, Articles 1.33, 3.42, 21.20, 21.21, 21.21-3, and 21.21-5, §26.20; Insurance Code, Chapter 26, §26.21; Insurance Code, Chapter 26; and Insurance Code, Articles 3.42 21.20, 21.21, 21.21-3, and 21.21-5, §26.22; Insurance Code, Chapter 26, §26.23; Insurance Code, Chapter 26, §26.24; Insurance Code, Chapter 26, Insurance Code, Articles 1.03A and 1.33, §26.25; Insurance Code, Chapter 26, and Insurance Code, Articles 21.20, 21.21, 21.21-3, and 21.21-5, §26.26; Insurance Code, Chapter 26, and Insurance Code, Articles 1.03A and 1. 10, §26.27; Insurance Code, Chapter 26, and Insurance Code, Articles 1.03A, 3.42.

§26.1. Statement of Purpose.

(a) This chapter is intended to implement the provisions of the Small Employer Health Insurance Availability Act, Insurance Code, Chapter 26. The general purposes of Insurance Code, Chapter 26, and this chapter are to provide for the availability of health insurance coverage to small employers and their employees; to ensure renewability of coverage; to regulate rating practices and establish limits on differences in rates between health benefit plans; to establish limitations on underwriting practices, eligibility requirements, and the use of pre-existing condition exclusions; to prescribe standard benefit provisions for three health benefit plans to be offered to all small employers; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small employer health insurance market.

(b) Insurance Code, Chapter 26, and this chapter are intended to promote broader spreading of risk in the small employer marketplace. Insurance Code, Chapter 26, and this chapter are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Health carriers that provide health benefit plans to small employers are intended to be subject to provisions of Insurance Code, Chapter 26, and this chapter.

§26.2. Forms Adopted and Incorporated by Reference. The forms relating to small employer health benefit plans are adopted and incorporated by reference in this chapter and have been filed with the Office of the Secretary of State. They are also printed as an appendix to this chapter The index to the appendix is found at §26.27 of this title (relating to Appendix). The forms can be obtained from the Texas Department of Insurance, Publications Department, MC 108-5A, P.O. Box 149104, Austin, Texas 78714-9104. They can also be obtained from the Department as sets of prototype policies.

§26.3. Severability. If any provision of this chapter or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the chapter and the application of its provisions to any persons under other circumstances shall not be affected thereby.

§26.4. Definitions. The following words and terms, when used in this chapter shall have the following meanings, unless the context clearly indicates otherwise.

Affiliated employer–A person connected by commonality of 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.

Agent–A person who may act as an agent for the sale of a health benefit plan under a license issued under Insurance Code, Article 20A. 15 or 20A.15A, or under Insurance Code, Chapter 21, Subchapter A.

Base premium rate–For each class of business and for a specific rating period, the lowest premium rate that is charged or that could be charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for small employer health benefit plans with the same or similar coverage.

Case characteristics–With respect to a small employer, the geographic area in which that employer's employees reside, the age and gender of the individual employees and their dependents, the appropriate industry classification as determined by the small employer carrier, the number of employees and dependents, and other objective criteria as established by the small employer carrier that are considered by the small employer carrier in setting premium rates for that small employer. The term does not include claim experience, health status, duration of coverage since the date of issuance of a health benefit plan, or whether a covered person is or may become pregnant.

Child–An unmarried natural child of the employee, including a newborn child, adopted child, including a child who the employee is seeking to adopt, natural child or adopted child of the employee's spouse, provided that the child resides with the employee.

Class of business–All small employers or a separate grouping of small employers established under Insurance Code, Chapter 26

Commissioner–The commissioner of insurance.

Department–The Texas Department of Insurance.

Dependent–A spouse; newborn child; child under the age of 19 years; child who is a full-time student under the age of 23 years and who is financially dependent on the parent; child of any age who is medically certified as disabled and dependent on the parent; and any person who must be covered under the Insurance Code, Article 3.51-6, §3D or §3E or the Insurance Code, Article 3.70-2(L).

Eligible employee–An employee who works on a full-time basis and who usually works at least 30 hours a week. The 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. The term does not include: an employee who works on a part-time, temporary, or substitute basis or an employee who is covered under another health benefit plan or an employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 United States Code, §1001, et seq).

Franchise insurance policy–An individual health benefit plan under which a number of individual policies are offered to a selected group of a small employer. The rates for such a policy may differ from the rate applicable to individually solicited policies of the same type and may differ from the rate applicable to individuals of essentially the same class.

HMO–A health maintenance organization subject to the Insurance Code, Chapter 26A.

Health benefit plan–A group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include the plans or coverage excluded under the Insurance Code, Article 26.02(9)(A)-(P), as follows:

(A) accident-only insurance coverage;

(B) credit insurance coverage;

(C) disability insurance coverage;

(D) specified disease coverage or other limited benefit policies;

(E) coverage of Medicare services under a federal contract;

(F) Medicare supplement and Medicare Select policies regulated in accordance with federal law;

(G) long-term care insurance coverage;

(H) coverage limited to dental care;

(I) coverage limited to care of vision;

(J) coverage provided by a single service health maintenance organization;

(K) insurance coverage issued as a supplement to liability insurance;

(L) insurance coverage arising out of a workers' compensation system or similar statutory system;

(M) automobile medical payment insurance coverage;

(N) jointly managed trusts authorized under 29 United States Code, §141 et seq that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 United States Code, §157;

(O) hospital confinement indemnity coverage; or

(P) reinsurance contracts issued on a stop-loss, quota-share, or similar basis.

Health carrier–Any entity authorized under the Insurance Code or another insurance law of this state that provides health insurance or health benefits in this state including an insurance company, a group hospital service corporation under the Insurance Code, Chapter 20, a health maintenance organization under the Texas Health Maintenance Organization Act (Insurance Code, Chapter 20A), and a stipulated premium company under the Insurance Code, Chapter 22.

Index rate–For each class of business as to a rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and corresponding highest premium rate.

Late enrollee–An eligible employee or dependent who requests enrollment in a small employer's health benefit plan after the expiration of the initial enrollment period established under the terms of the first plan for which that employee or dependent was eligible through the small employer. An eligible employee or dependent is not a late enrollee if:

(A) the individual:

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

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

(iii) 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, the death of a spouse, or divorce; and

(iv) requests enrollment not later than the 31st day after the date on which coverage under another employer health benefit plan terminates;

(B) the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or

(C) a court has ordered coverage to be provided for a spouse or minor child under a covered employee's plan and request for enrollment is made not later than the 31st day after issuance of the date on which the court order is issued.

Limited benefit policy–For purposes of this chapter and Insurance Code, Chapter 26, only, a policy of accident and sickness insurance:

(A) that provides for payment of benefits only upon the occurrence of certain contingencies, such as cancer or other specified disease, in contrast to policies covering all contingencies other than those excluded; or

(B) that provides only the type of coverage set forth in §3.3071 of this title (relating to Minimum Standards for Basic Hospital Expense Coverage), §3.3072 of this title (relating to Minimum Standards for Basic Medical Surgical Expense Coverage); or §3.3075 of this title (relating to Minimum Standards for Disability Income Protection Coverage), where the policy fails to meet the minimum standards as provided in those sections; and

(C) a policy will not be deemed to be a limited benefit policy:

(i) solely due to a deductible in excess of the minimum standard provided in §3.3071(4) of this title (relating to Minimum Standards for Basic Hospital Expense Coverage); or

(ii) if it provides any coverage or benefit in addition to or other than the coverage and benefits set out respectively in §§3.3071, 3.3072, or 3.3075.

New entrant-An eligible employee, or the dependent of an eligible employee, who becomes part of a small employer group after the initial period for enrollment in a health benefit plan. After the initial enrollment period, this includes any employee or dependent who becomes eligible for coverage and who is not a late enrollee.

New business premium rate-For each class of business as to a rating period, the lowest premium rate that is charged or offered or that could be charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued small employer health benefit plans that provide the same or similar coverage.

Person-An individual, corporation, partnership, association, or other private legal entity.

Policy year-For purposes of Insurance Code, Chapter 26, and this chapter, a 365 day period that begins on the policy's effective date or a period of one full calendar year, under a health benefit plan providing coverage to small employers and their employees, as defined in the policy. Small employer carriers must use the same definition of policy year in all small employer health benefit plans.

Preexisting condition provision-A provision that denies, excludes, or limits coverage as to a disease or condition for a specified period after the effective date of coverage.

Premium-All amounts paid by a small employer and eligible employees as a condition of receiving coverage from a small employer carrier, including any fees or other contributions associated with a health benefit plan.

Rating period-A calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

Renewal date-For each small employer's health benefit plan, the earlier of the date (if any) specified in such plan (contract) for renewal; the policy anniversary date; or the date on which the small employer's plan is changed. A change in the premium rate due solely to the addition of an employee or dependent is not considered a renewal date. For association or multiple employer trusts group health benefit plans, small employer carriers may use the date specified for renewal or the policy anniversary date, of either the master contract or of each small employer in the association or trust, in determining the renewal date. Small employer carriers must use the same method of determining renewal dates for all small employer health benefit plans.

Risk characteristic-The health status, claims experience, duration of coverage, or any similar characteristic related to the health status or experience of a small employer group or of any member of a small employer group.

Risk load-The percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

Small employer-A person that is actively engaged in business and that, on at least 50% 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 whom were employed in this state.

Small employer carrier-A health carrier, to the extent that that health carrier is offering, delivering, issuing for delivery, or renewing health benefit plans subject to the Insurance Code, Chapter 26, under Article 26.06(a).

Small employer health benefit plan-The preventive and primary care benefit plan, the in-hospital benefit plan, or the standard health benefit plan described by the Insurance Code, Chapter 26, Subchapter E, or any other health benefit plan offered to a small employer under the Insurance Code, Article 26.42(d).

Standard benefit plans-The preventive and primary care benefit plan, the in-hospital benefit plan and the standard health benefit plan required to be offered by health carriers, excluding HMOs, under the Insurance Code, Chapter 26, Subchapter E. For HMOs, the standard benefit plans means the preventive and primary care benefit plan and the standard health benefit plan that may be offered by an HMO, as provided under the Insurance Code, Chapter 26, Subchapter E.

Waiting period-A period of time, established by a small employer, during which a new employee is not eligible for coverage and which cannot exceed 90 days from the first day of employment.

§26.5. Applicability and Scope.

(a) Except as otherwise provided in this chapter, this chapter shall apply to any health benefit plan providing health care benefits covering three or more eligible employees of a small employer, whether provided on a group or individual franchise basis, regardless of whether the policy or certificate was issued in this State, if the plan:

(1) meets one or more of the conditions listed in subparagraphs (A)-(C) of this paragraph and the Insurance Code, Article 26.06(a)(i)-(3):

(A) a portion of the premium or benefits is paid by or on behalf of small employers;

(B) a covered individual is reimbursed, whether through wage adjustments or otherwise, by or on behalf of a small employer for a portion of the premium; or

(C) the health plan is treated by the employer or by a covered individual as part of a plan or program for the purposes of 26 United States Code, §106 or §162;

(2) is in effect at any time after September 1, 1993.

(b) Health benefit plans issued prior to September 1, 1993, to small employers and/or employees of a small employer, including franchise insurance policies, which are changed in any way, shall be amended to comply with all provisions of the Insurance Code, Chapter 26, and this chapter on the later of the date of change or January 1, 1994, except that a premium rate for a rating period may exceed the ranges set forth in Insurance Code, Article 26.32, until September 1, 1995, and such rate shall be calculated as provided in Insurance Code, Article 26.34. As long as health benefit plans issued to small employers prior to September 1, 1993, are not changed in any way, the plans shall not be required to be amended to comply with the provisions of the Insurance Code, Chapter 26, and this chapter.

(c) For purposes of this chapter only, a health benefit plan will be considered to be changed if it is in any way amended, except those changes mandated by state or federal law. Changes and amendments include, but are not limited to, the following:

(1) adding or removing benefits;

(2) altering terms and conditions of the plan, benefits, deductibles, copayments, or other policy provisions under the plan;

(3) excluding one or more of the previously covered employees or dependents from the plan; or

(4) limiting or restricting benefits for one or more of the employees or dependents covered under the plan.

(d) Health benefit plans issued or renewed to small employers and their em-

ployees on or after September 1, 1993, and prior to January 1, 1994:

(1) that are specifically offered, marketed, represented, issued or delivered as "small employer health benefit plans" during this time frame shall comply with all provisions of the Insurance Code, Chapter 26, when issued or renewed, and shall be amended to comply with all provisions of this chapter no later than January 1, 1994;

(2) that are not specifically offered, marketed, represented, issued or delivered as "small employer health benefit plans" during this time frame shall be amended to comply with all provisions of the Insurance Code, Chapter 26, and this chapter, on the first renewal date occurring on or after January 1, 1994.

(e) Health benefit plans that are offered, marketed, represented, issued, or delivered for issue to small employers and their employees, on and after January 1, 1994, shall comply with all provisions of the Insurance Code, Chapter 26, and this chapter beginning January 1, 1994.

(f) If a health carrier continues to provide coverage to small employers and their employees under existing health benefit plans and elects not to continue to offer, deliver, or issue for delivery, health benefit plans to small employers and their employees, the health carrier will only be considered a small employer carrier for purposes of renewing such existing plans. In this case, the health carrier shall notify the small employer of certain information. The notice shall be provided at least 60 days prior to the first renewal date occurring on or after January 1, 1994, except for renewal dates occurring prior to March 1, 1994, and for those renewal dates, the notice shall be given as soon as possible before the renewal date. The notice shall state that:

(1) the health carrier (the current health carrier of the small employer's employee health benefit plans) has elected not to continue to offer new health benefit plans in the small employer market;

(2) other health benefit plans may be available to the small employer through other small employer carriers and that such other plans should be compared against existing plans to determine which plan is more beneficial.

(g) If a health carrier continues to provide coverage to small employers and their employees under existing health benefit plans and elects to continue to offer, issue, and issue for delivery, health benefit plans to small employers and their employees, the health carrier shall notify the small employer of certain information. The notice shall be provided at least 60 days prior to the first renewal date occurring on or after January 1, 1994, except for renewal dates occurring prior to March 1, 1994, and for those renewal dates, the notice shall be given as soon as possible before the renewal date. The notice shall:

(1) offer the small employer the option of continuing the existing health benefit plan or plans or purchasing new small employer benefit plans in accordance with Insurance Code, Chapter 26, and this chapter; and

(2) provide notice that such other plans should be compared against existing plans to determine which plan is more beneficial.

(h) The provisions of the Insurance Code, Chapter 26, and this chapter shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

(i) If a small employer or the employees of a small employer are issued a health benefit plan under the provisions of Insurance Code, Chapter 26, and this chapter, and the small employer subsequently employs more than 50 eligible employees or less than three eligible employees, the provisions of Insurance Code, Chapter 26 and this chapter shall continue to apply to that particular health plan, until the first renewal date following the last renewal date on which the employer was qualified for coverage as a small employer under the definition of small employer found in §26.4 of this chapter (relating to Definitions). A health carrier providing coverage to such an employer shall, within 60 days of becoming aware that the employer has more than 50 eligible employees or less than three eligible employees, but not later than the first renewal date occurring after the small employer has ceased to be a small employer, notify the employer that the protections provided under the Insurance Code, Chapter 26, and this chapter shall cease to apply to the employer.

(j) If a health benefit plan is issued to an employer that is not a small employer as defined in the Insurance Code, Chapter 26, but subsequently the employer becomes a small employer, the provisions of the Insurance Code, Chapter 26, and this chapter, shall apply to the health benefit plan, if changed in any way, upon the later of the date of any change to the plan or January 1, 1994. An employer may become a small employer due to several reasons, including, but not limited to, the loss or change of work status of one or more employees, or the employer has moved to this state from another state and has a health benefit plan that was issued in the other state. The health carrier providing a health benefit plan to such an employer:

(1) shall not be considered to have elected to offer, issue or issue for delivery health benefit plans to small employers under the provisions of the Insurance Code, Chapter 26, and this chapter, solely because the health carrier continues to provide coverage under the health benefit plan to the employer and employees of the employer; however, for purposes of such existing health benefit plans, the health carrier will be considered a small employer carrier; and

(2) shall, within 60 days of becoming aware that the employer has 50 or fewer eligible employees, notify the small employer of the options that will be available to the small employer under the Insurance Code, Chapter 26, and this chapter, including the small employer's option to purchase a small employer health benefit plan from the employer's current health carrier, if the carrier is offering such coverage, or from any small employer carrier willing to accept the group.

(k) If a small employer has employees in more than one state, the provisions of the Insurance Code, Chapter 26, and this chapter shall apply to a health benefit plan issued to the small employer if:

(1) the majority of eligible employees of such small employer are employed in this state on the issue date or renewal date; or

(2) the primary business location of the small employer is in this state on the issue date or renewal date and no state contains a majority of the eligible employees of the small employer.

§26.6. Status of Health Carriers as Small Employer Carriers and Geographic Service Area.

(a) No later than December 15, 1993, each health carrier providing health benefit plans in this state shall make a filing with the commissioner indicating whether the health carrier will or will not offer, renew, issue, or issue for delivery, health benefit plans to small employers in this state as defined in Insurance Code, Chapter 26, and this chapter. The required filing shall include certification form (Form Number 2055 CERT SEHC STATUS) completed according to the carrier's status and shall at least provide a statement to the effect of one of the following:

(1) the health carrier intends to offer, renew, issue, and issue for delivery health benefit plans to small employers and their employees and therefore will operate in accordance with the 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 and their employees; however, the health carrier intends to renew health benefit plans issued prior to January 1, 1994, and with respect to such business, intends to comply with the 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 and their employees 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.

(b) After December 15, 1993, if a health carrier chooses to change its election under subsection (a)(1), (2), or (4) of this section, the health carrier shall notify the commissioner of its new election at least 30 days prior to the date the health carrier intends to begin operations under the new election. This notification shall be made on Form Number 2055 CERT SEHC STATUS.

(c) Upon election to become a small employer carrier, the health carrier shall establish geographic service areas within which the health carrier reasonably anticipates it will have the capacity to deliver services adequately to small employers in each established geographic service area. The geographic service areas shall be defined in terms of counties or zip codes, to the extent possible, and shall be submitted in conjunction with any filing of a small employer health benefit plan. If the service area cannot be defined by counties or zip code, a map which clearly shows the geographic service areas is required to be submitted in conjunction with the filing of the small employer health benefit plan.

(d) Health carriers providing coverage under any health benefit plans issued to small employers and/or their employees, whether on a group or franchise basis, shall be considered small employer carriers for purposes of such plans, and shall comply with all provisions of the Insurance Code, Chapter 26, and this chapter, as applicable.

(e) A health carrier that continues to provide coverage pursuant to subsection (a)(2) of this section shall not be eligible to participate in the reinsurance program established under Insurance Code, Chapter 26.

§26.7. Requirement to Insure Entire Groups.

(a) A small employer carrier that offers coverage to a small employer and its employees shall offer to provide coverage to each eligible employee and to each dependent of an eligible employee. Except as provided in subsection (b) of this section, the small employer carrier shall provide the same health benefit plan to each such employee and dependent.

(b) If elected by the small employer, a small employer carrier may offer the eligible employees of a small employer the option of choosing among one or more health benefit plans, provided that each eligible employee may choose any of the plans offered. If at least 40% of eligible employees elect additional coverage, as provided in §26.15 of this chapter (relating to Additional Coverage), each eligible employee shall have the option to choose such additional coverage. Except as provided in the Insurance Code, Article 26. 21 and Article 26.49 (with respect to exclusions for preexisting conditions), the choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the eligible employees or their dependents.

(c) A small employer carrier may require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents of eligible employees as defined in Insurance Code, Article 26.02. If the small employer carrier requires such list, then the carrier may also require the small employer to provide appropriate supporting documentation (such as a W-2 Summary Wage and Tax Form) to verify the information required under this subsection.

(d) A small employer carrier shall secure a waiver with respect to each eligible employee and each dependent of such an eligible employee who declines an offer of coverage under a health benefit plan provided to a small employer. Waivers shall be maintained by the small employer carrier for a period of six years. The waiver shall be signed by the eligible employee (on behalf of such employee or the dependent of such employee) and shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall:

(1) require that the reason for declining coverage be stated on the form;

(2) include a written warning of the penalties imposed on late enrollees; and

(3) include a statement that the eligible employee and dependents were not induced or pressured by the small employer, agent, or health carrier, into declining coverage, but elected of their own accord to decline such coverage.

(e) A small employer carrier shall not provide coverage to a small employer or the employees of such employer if the health carrier, or an agent for such health carrier, has reason to believe that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

(f) An agent shall notify a small employer carrier, prior to submitting an application for coverage with the health carrier on behalf of a small employer or employee of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee) to decline coverage due to the individual's risk characteristics.

(g) New entrants to a small employer group shall be offered an opportunity to enroll in the health benefit plan currently held by such employer group or shall be offered an opportunity to enroll in the health benefit plan if the plan is provided through an individual franchise policy or more than one plan is available. If a small employer carrier has offered more than one health benefit plan to eligible employees of a small employer group pursuant to subsection (b) of this section, or if 40% of the eligible employees of the small employer group have elected to receive additional coverage under §26.15 of this title (relating to Additional Coverage), the new entrant shall be offered the same choice of health benefit plans as the other employees (members) in the group. A new entrant that does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the health carrier, provided that the period provided to enroll in the health benefit plan complies with subsection (h) of this section.

(h) Periods provided for enrollment in and application for any health benefit plan provided to a small employer group shall comply with the following:

(1) the enrollment period extends at least 30 days after the date the new entrant begins employment or becomes eligible for coverage;

(2) the new entrant is notified of his or her opportunity to enroll at least 30 days in advance of the last date enrollment is permitted; and

(3) a period of at least 31 days following the date of employment is provided during which the new entrant's application for coverage may be submitted

(i) A small employer carrier shall not apply a waiting period, elimination period or other similar limitation of coverage (other than an exclusion for pre-existing

medical conditions consistent with the Insurance Code, Article 26.21 and Article 26.49) with respect to a new entrant, that is longer than 90 days. Any waiting period applied to a new entrant, shall be based on the waiting period established by the small employer.

(j) New entrants to a small employer group shall be accepted for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents, except that a health carrier may exclude coverage for pre-existing medical conditions, to the extent allowed under the Insurance Code, Article 26. 21 and Article 26.49.

(k) A small employer carrier may assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of the Insurance Code, Chapter 26, Subchapter D, and this chapter. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant into the group.

(l) In the case of an eligible employee (or dependent of an eligible employee) who was excluded from coverage, not eligible for coverage, or denied coverage by a small employer carrier, in the process of providing a health benefit plan to an eligible small employer (as defined in the Insurance Code, Chapter 26 and this chapter), the small employer carrier shall provide an opportunity for the eligible employee (or dependent(s) of such eligible employee) to enroll in the health benefit plan issued to the small employer or the employees of the small employer:

(1) on the first renewal date occurring on or after January 1, 1994, if the plan was issued between September 1, 1993, and January 1, 1994; and

(2) on the later of the date of any change in the plan or January 1, 1994, if the plan was issued prior to September 1, 1993.

(m) A small employer carrier may require an individual who requests enrollment under this section to sign a statement indicating that such individual sought coverage under the group contract or franchise policy (other than as a late enrollee) and that the coverage was not offered or provided to the individual.

(n) The opportunity to enroll shall meet the following requirements.

(1) The opportunity to enroll under this section shall comply with subsection (h) of this section, and shall begin:

(A) on the first renewal date occurring on or after January 1, 1994, if the plan was issued between September 1, 1993 and January 1, 1994; and

(B) on the later of the date of any change in the plan or January 1, 1994, if the plan was issued prior to September 1, 1993.

(2) Eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this section shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with subsection (j) of this section.

(3) The terms of coverage offered to an individual described in subsection (l) of this section may exclude coverage for pre-existing medical conditions only if the health benefit plan currently held by the small employer contains such an exclusion, provided that the exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this subsection.

(4) A small employer carrier shall provide written notice at least 45 days prior to the opportunity to enroll provided in this section, or if less than 45 days are available, within five working days after determination that subsections (g)-(m) of this section apply to each small employer insured under a health benefit plan offered by such health carrier. The notice shall clearly describe the rights granted under subsections (g)-(m) of this section to employees and dependents who were previously excluded from, not eligible for, or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan.

§26.8. Contribution and Participation Requirements.

(a) Health carriers may require small employers to answer questions designed to determine the level of contribution by the small employer, the number of eligible employees of the small employer, and the percentage of participation of eligible employees of the small employer.

(b) Health carriers shall require that small employers pay at least 75% of the premium for the plan selected by the employer for each eligible employee who elects to be covered by at least one of the small employer health benefit plans selected by the employer, in accordance with the Insurance Code, Article 26.21(b).

(1) A health carrier shall treat all similarly situated small employer groups in a consistent and uniform manner when terminating health benefit plans due to failure of the small employer to meet the 75% contribution requirement.

(2) If a small employer fails to meet the 75% contribution requirement for a small employer health benefit plan, the health carrier may terminate coverage as provided under the plan in accordance with the terms and conditions of the plan requiring such contribution and in accordance with the Insurance Code, Articles 26.23, 26.24, and 26.25.

(c) Coverage under a small employer health benefit plan is available if at least 90% of the eligible employees of a small employer elect to be covered, as provided in the Insurance Code, Article 26.21(b).

(1) A health carrier shall treat all similarly situated small employer groups in a consistent and uniform manner when terminating health benefit plans due a participation level of less than 90% of the eligible employees of the small employer.

(2) If a small employer fails to meet the 90% participation requirement for a small employer health benefit plan, for a period of at least six consecutive months, the health carrier may terminate coverage under the plan upon the first renewal date following the end of the six month consecutive period during which the 90% participation requirement was not met, provided that the termination shall be in accordance with the terms and conditions of the plan concerning termination for failure to meet the 90% participation requirement and in accordance with the Insurance Code, Articles 26.23, 26.24, and 26.25.

(d) In determining whether an employer has participation by 90% of the eligible employees, if 90% of the eligible employees is not a whole number, the result of applying 90% to the number of eligible employees shall be rounded down to the nearest whole number; the result shall represent 90% participation for purposes of compliance with such requirement. For example: 90% of five employees is 4.5, so 4.5 would be rounded down to four; therefore, 90% participation by a five employee group will be achieved if four of the eligible employees participate.

§26.9. Exclusions, Limitations, Waiting Periods and Pre-existing Conditions and Restrictive Riders.

(a) All health benefit plans that provide coverage for small employers and their employees as defined in the Insurance Code, Article 26.02(21) and §26.4 of this title (relating to Definitions) shall comply with the following requirements. All such plans issued to small employers after January 1, 1994, shall comply with these provisions; plans issued between September 1, 1993, and January 1, 1994, shall be

amended to comply with these provisions on the first renewal date after January 1, 1994; and plans issued prior to September 1, 1993, must be amended to comply with these provisions if the policies are changed in any way as described in subsections (b), (c), and (j) of §26.5 of this title (relating to Applicability and Scope).

(1) A small employer carrier shall not exclude any eligible employee or dependent (including a late enrollee, who would otherwise be covered under a small employer's health benefit plan), except to the extent permitted under the Insurance Code, Article 26.21(g).

(2) A small employer carrier shall not limit or exclude (by use of rider, amendment or other provision of the plan, applicable to a specific individual) coverage by type of illness, treatment, medical condition, or accident, except for preexisting conditions or diseases, as permitted the under Insurance Code, Article 26.49.

(3) A small employer health benefit plan may not limit or exclude initial coverage of a newborn child of a covered employee. Any coverage of a newborn child of an employee under this subsection terminates on the 31st day after the date of the birth of the child unless·

(A) dependent children are eligible for coverage; and

(B) notification of the birth and any required additional premium are received by the small employer carrier not later than the 30th day after the date of birth.

(4) A late enrollee may be excluded from coverage for 18 months from the date of application or may be subject to a 12-month preexisting condition provision as described by the Insurance Code, Article 26.49(b), (c), (d), and (e). If both a period of exclusion from coverage and a preexisting condition provision are applicable to a late enrollee, the combined period of exclusion may not exceed 18 months from the date of the late application.

(5) A pre-existing condition provision in a small employer health benefit plan may not apply to coverage for a disease or condition other than a disease or condition:

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

(B) 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.

(6) A pre-existing condition provision in a small employer health benefit plan shall not apply to an individual who was continuously covered for a minimum period of 12 months by a health benefit plan that was in effect up to a date not more than 60 days before the effective date of coverage under the small employer health benefit plan.

(7) In determining whether a pre-existing condition provision applies to an individual covered by a small employer health benefit plan, the small employer carrier shall credit the time the individual was covered under a previous health benefit plan if the previous coverage was in effect at any time during the 12 months preceding the effective date of coverage under a small employer health benefit plan. If the previous coverage was issued by a health maintenance organization, any waiting period that applied before that coverage became effective also shall be credited against the pre-existing condition provision period.

(8) A small employer may establish a waiting period, that cannot exceed 90 days from the first day of employment, during which a new employee is not eligible for coverage

(9) A pre-existing condition provision in a small employer health benefit plan may exclude coverage for a pregnancy existing on the effective date of the coverage, except as provided by paragraph (6) of this subsection.

(b) In order to determine if preexisting conditions as defined in the Insurance Code, Article 26.02(16), exist, a small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each dependent of an eligible employee at the time such employee or dependent initially enrolls into the health benefit plan provided by the small employer carrier The small employer carrier shall have the responsibility to contact the source of such previous or existing coverage to resolve any questions about the benefits or limitations related to such previous or existing coverage

§26.10. Establishment of Classes of Business

(a) A small employer carrier that establishes more than one class of business pursuant to the provisions of the Insurance Code, Article 26 31, shall maintain on file for inspection by the commissioner the following information with respect to each class of business so established:

(1) a description of each criterion employed by the health carrier (or any of its agents) for determining membership in the class of business;

(2) a statement describing the justification for establishing the class as a separate class of business and documentation that the establishment of the class of business is intended to reflect substantial differences in expected claims experience or administrative costs related to the reasons set forth in the Insurance Code, Chapter 26, Subchapter D; and

(3) a statement disclosing which, if any, health benefit plans are currently available for purchase in the class and any significant limitations related to the purchase of such plans.

(b) A health carrier may not directly or indirectly use group size or the trade or occupation of the employees of a small employer or the industry or type of business of the small employer as criteria for establishing eligibility for a health benefit plan or for a class of business.

§26.11. Restrictions Relating to Premium Rates.

(a) A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the health carrier's discretion, the manual shall specify the criteria and factors considered by the health carrier in exercising such discretion.

(b) A small employer carrier shall not modify the rating method used in the rate manual for a class of business until the change has been approved as provided in this section. The commissioner's approval is of the change in rating methodology. It is not an approval of the rates themselves. The approval is required in order to determine that the methodology used is actuarially sound and appropriate to assure compliance with the Insurance Code, Chapter 26, and this chapter. The commissioner may approve a change to a rating method if the commissioner finds that the change is reasonable, actuarially appropriate, and consistent with the purposes of the Insurance Code, Chapter 26 and this chapter, and will ensure that differences in rates charged for each small employer health benefit plan are reasonable and reflect objective differences in plan design.

(1) A small employer health carrier may modify the rating method for a class of business only with prior approval of the commissioner. A small employer health carrier requesting to change the rating

method for a class of business shall make a filing with the commissioner at least 60 days prior to the proposed date of the change. The filing shall contain at least the following information:

(A) the reasons the change in rating method is being requested;

(B) a complete description of each of the proposed modifications to the rating method;

(C) a description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals and a description of the types of groups or individuals whose premium rates may change by more than 10% due to the proposed change in rating method (not including general increases in premium rates applicable to all small employers in a health benefit plan);

(D) a certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(E) a certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of the Insurance Code, Chapter 26, Subchapter D.

(2) For the purpose of this section a change in rating method shall mean:

(A) a change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

(B) a change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(C) a change in the method of allocating expenses among health benefit plans in a class of business; or

(D) a change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds 10%. For the purpose of this paragraph, a change in a rating factor shall mean the cumulative change with respect to such factor considered over a 12 month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a 12 month period, the health carrier shall consider the cumulative effect of all such changes in applying the 10% test under this paragraph.

(c) Each rate manual developed pursuant to subsection (a) of this section shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(1) A small employer carrier may not use case characteristics other than those specified in the Insurance Code, Article 26.36(c), without the prior approval of the commissioner. A small employer carrier seeking such an approval shall make a filing with the commissioner for a change in rating method under subsection (b) of this section.

(2) A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each such health benefit plan. Case characteristics may include the employer's industry classification consistent with the Insurance Code, Article 26.33(c). Case characteristics shall be applied without regard to the risk characteristics of a small employer.

(3) The rate manual developed pursuant to subsection (a) of this section shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(4) Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan

(5) Each rate manual developed pursuant to subsection (a) of this section shall provide for premium rates to be developed in a two step process. In the first step, a base premium rate shall be developed for the small employer group without regard to any risk characteristics of the group. In the second step, the resulting base premium rate may be adjusted by a risk load, subject to the provisions of the Insurance Code, Chapter 26, Subchapter D, to reflect the risk characteristics of the group.

(6) Except as provided in this subsection, a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge. A small employer health carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than $5.00 per month per employee and is applied in a uniform manner to each health benefit plan in a class of business.

(7) A small employer carrier shall allocate administrative expenses to the small employer health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to subsection (a) of this section shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(8) Each rate manual developed pursuant to subsection (a) of this section shall be maintained by the health carrier for a period of six years. Updates and changes to the manual shall be maintained with the manual.

(9) Each rate manual and the rating practices of a small employer carrier shall comply with any applicable rules.

(d) If group size is used as a case characteristic by a small employer carrier, the highest rate factor associated with a group size classification shall not exceed the lowest rate factor associated with such a classification by more than 20%.

(e) The restrictions related to changes in premium rates in the Insurance Code, Article 26.33 and Article 26.34, shall be applied as follows.

(1) A small employer carrier shall revise its rate manuals each rating period to reflect changes in base premium rates and changes in new business premium rates

(2) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate is less than or the same as the percentage change in the base premium rate, the change in the new business pre-

mium rate shall be deemed to be the change in the base premium rate for the purposes of the Insurance Code, Article 26.33 and Article 26.34.

(3) If, for any health benefit plan with respect to any rating period, the percentage change in the new business premium rate exceeds the percentage change in the base premium rate, the health benefit plan shall be considered a health benefit plan into which the small employer carrier is no longer enrolling new small employers for the purposes of the Insurance Code, Article 26.33 and Article 26.34.

(4) If, for any rating period, the change in the new business premium rate for a health benefit plan differs from the change in the new business premium rate for any other health benefit plan in the same class of business by more than 20%, the health carrier shall make a filing with the commissioner containing a complete explanation of how the respective changes in new business premium rates were established and the reason for the difference. The filing shall be made at least 60 days prior to the beginning of the rating period when the change would be applicable. The filing is for the purpose of allowing the commissioner to determine whether the methodology used is actuarially sound and appropriate to insure compliance with the Insurance Code, Chapter 26.

(5) A small employer carrier shall keep on file for a period of at least six years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

(f) Changes in premium rates and revised premium rates shall comply with the following.

(1) Except as provided in subsection (e) of this section, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (as shown in the rate manual as revised for the rating period), multiplied by one plus the sum of:

(A) the risk load applicable to the small employer during the previous rating period; and

(B) 15% (prorated for periods of less than one year).

(2) In the case of a health benefit plan into which a small employer carrier is no longer enrolling new small employers, a change in premium rate for a small employer shall produce a revised premium rate that is no more than the base premium rate for the small employer (given its present composition and as shown in the rate manual in effect for the small employer at the beginning of the previous rating period), multiplied by one plus the lesser of:

(A) the change in the base rate; or

(B) the percentage change in the new business premium for the most similar health benefit plan into which the small employer carrier is enrolling new small employers, multiplied by one plus the sum of:

(i) the risk load applicable to the small employer during the previous rating period; and

(ii) 15% (prorated for periods of less than one year).

(3) In the case of a health benefit plan described in the Insurance Code, Article 26.33(c), if the current premium rate for the health benefit plan exceeds the ranges set forth in the Insurance Code, Article 26.32(b), the formulae set forth in paragraphs (1) and (2) of this subsection will be applied as if the 15% adjustment provided in paragraph (1)(B) and paragraph (2)(B)(ii) were a zero percent adjustment.

(4) Notwithstanding the provisions of paragraphs (1) and (2) of this subsection, a change in premium rate for a small employer shall not produce a revised premium rate that would exceed the limitations on rates provided in the Insurance Code, Article 26.32(c).

(g) HMOs shall follow the rating requirements set out in this section for the prototype benefit plans authorized by the Insurance Code, Article 26. 42 and this chapter. HMOs offering any state approved, federally qualified plan described in the Insurance Code, Article 26.48, and §26.14 of this title (relating to Coverage) shall establish premium rates for those plans in accordance with formulas or schedules of charges filed with the department under the procedures set forth in the Insurance Code, Article 20A.09(b) and Subchapter H of Chapter 11 of this title (relating to Schedule of Charges).

§26.12. Disclosure. In connection with the offering for sale of any small employer health benefit plan, each small employer carrier and each agent shall make a reasonable disclosure, as part of its solicitation and sales material, of

(1) the extent to which premium rates for a specific small employer are established or adjusted based on the actual or expected variation in claim costs or the actual or expected variation in health status of the employees of the small employer and their dependents;

(2) provisions concerning the small employer carrier's right to change premium rates and the factors other than claim experience that affect changes in premium rates;

(3) provisions relating to renewability of policies and contracts; and

(4) any pre-existing condition provision.

§26.13. Rules Related to Fair Marketing.

(a) A small employer carrier shall market each of its small employer health benefit plans to small employers in this state. A small employer carrier may not suspend the marketing or issuance of the small employer benefit plans unless the health carrier has good cause and has received the prior approval of the commissioner or the commissioner's designee. In marketing the standard benefit plans to small employers, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other small employer health benefit plans to small employers. Any agent authorized by a small employer carrier to market health benefit plans to small employers in this state shall also be authorized to market the small employer health benefit plans.

(b) A small employer carrier, other than an HMO, shall offer at least the preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan to any small employer that applies for or makes an inquiry regarding health insurance coverage from the small employer carrier. An HMO shall offer the small employer health benefit plans that the HMO has filed for use in the small employer market. The offer may be provided directly to the small employer or delivered through an agent. The offer shall be in writing and shall include at least the following information:

(1) a general description of the benefits contained in the preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan, as applicable, and any other health benefit plan being offered to the small employer;

(2) information describing how the small employer may enroll in the plans; and

(3) information set out in the Insurance Code, Article 26.40.

(c) A small employer carrier shall provide a price quote to a small employer (directly or through an authorized agent) within ten working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small em-

ployer (directly or through an authorized agent) within five working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

(d) A small employer carrier, other than an HMO, shall not apply more stringent or detailed requirements related to the application process for the standard benefit plans, including the preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan than are applied for other health benefit plans offered by the health carrier to small employers. An HMO shall not apply more stringent or detailed requirements related to the application process for the standard benefit plans, including any preventive and primary care benefit plan and the standard health benefit plan, than are applied for other health benefit plans offered by the HMO to small employers.

(e) If a small employer carrier denies coverage under a health benefit plan to a small employer on the basis of a risk characteristic, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to confidentiality of medical information). The written denial shall be accompanied by a written explanation of the guaranteed availability of the small employer health benefit plans beginning in September, 1995, when guaranteed issue is required.

(f) A small employer carrier shall establish and maintain a means to provide information to small employers who request information on the availability of small employer health benefit plans in this state. The information provided to small employers shall at least include information about how to apply for coverage from the health carrier and may include the names and phone numbers of agents located geographically proximate to the caller or such other information that is reasonably designed to assist the caller to locate an authorized agent or to otherwise apply for coverage.

(g) The small employer carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except that, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement, subject to the requirements of the Insurance Code, Chapter 26.

(h) A small employer carrier may not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

(i) Health carriers offering individual and group health benefit plans in this state shall be responsible for determining whether the plans are subject to the requirements of the Insurance Code, Chapter 26, and this chapter. Health carriers shall elicit the following information from applicants for such plans at the time of application.

(1) whether or not any portion of the premium will be paid by or on behalf of a small employer;

(2) whether or not a covered individual is reimbursed, whether through wage adjustment or otherwise, by or on behalf of the small employer; and

(3) whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under §162 or §106 of the United States Internal Revenue Code of 1986 (26 United States Code, §106 or §162).

(j) If a small employer carrier fails to comply with subsection (i) of this section, the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with subsection (i) of this section.

§26.14. Coverage.

(a) Every small employer carrier, except HMOs, shall as a condition of transacting business in this state with small employers, offer to small employers at least three standard benefit plans, including the preventive and primary care benefit plan, the in-hospital benefit plan and the standard health benefit plan, as provided under the Insurance Code, Articles 26.42-26 49.

(b) In addition to the three standard benefit plans required to be offered to small employers as provided in the Insurance Code, Chapter 26, small employer carriers may, subject to the provisions of the Insurance Code, Article 26.42(d) and this chapter, offer other health benefit plans to small employers, as provided in the Insurance Code, Article 26.42(d). Such other health benefit plans shall comply with all provisions of Chapter 26 and this chapter, except that provisions defining the specific benefits required under the three required standard benefit plans are not applicable. The Insurance Code, Article 26.06(c), does not apply to a health benefit plan offered to a small employer as provided under the Insurance Code, Article 26 42(d).

(c) Instead of the standard benefit plans described by this chapter, a health maintenance organization may offer a state-approved health benefit plan that complies with the requirements of Title XI, Public Health Service Act (42 United States Code, §300e et seq) and rules adopted under that Act. An HMO may also offer two of the three prototype plans described in the Insurance Code, Article 26.45 and Article 26.47; including the Preventive and Primary Care Benefit Plan and the Standard Health Benefit Plan. HMOs may not offer the In-Hospital Benefit Plan, as that plan does not comply with either state or federal law regarding the operation of HMOs.

(d) Coverage under a conversion or continuation of any small employer health benefit plan provided by a small employer carrier other than an HMO shall provide an option for conversion/continuation which complies with all provisions of Subchapter F of Chapter 3 of this title (relating to Group Health Insurance Mandatory Conversion Privilege). An HMO shall provide coverage for conversion or continuation of any small employer health benefit plan which complies with the requirements of §11.506(7) or (8) of this title (relating to Mandatory Provisions· Group and Non-Group Agreement and Group Certificate).

(e) Each health benefit plan, certificate, policy, rider, or application used by health carriers to provide coverage to small employers and their employees shall comply with the Insurance Code, Article 26.43; be written in plain language; and meet the requirements of Subchapter G of Chapter 3 of this title (relating to Plain Language Requirements) Requirements for use of plain language are not applicable to a health benefit plan group master policy or a policy application or enrollment form for a health benefit plan group master policy.

(f) Every small employer carrier providing health benefit plans to small employers is required to offer dependent coverage. Dependent coverage may be paid for by the employer, the employee, or both.

(g) This section contains requirements for optional prototype policy forms. The policy forms described in this subsection are adopted by reference to complete a prototype policy and/or certificate when combined with the required prescribed benefit prototype policy forms outlined in this section. The prototype policy forms have been developed to facilitate implementation of the Insurance Code, Chapter 26 and to streamline the policy approval process. Small employer carriers are encouraged to use all of the prototype policy forms as described in this subsection to expedite the approval process Each form has a unique form number appearing in the lower left-hand corner and small employer carriers may use one or any number of the prototype forms. Alternate language, except for variables indicated by brackets, must be filed for review and approval under a different form number using 2055 as part of the form number Additional filing requirements are outlined in §26.19 of this title.

(I) This paragraph describes policy face pages.

(A) The group policy face pages are described in this subparagraph. These prototype policies provide for the entire contract to include any applications, the certificate of insurance and any attached riders. If the small employer carrier elects to use policies other than the prototype forms, this shell format shall be used with any small employer health benefit plan. Each policy face page, whether or not the prototype form is used, shall include the small employer carrier name and address; policyholder name (and industry, if issued on a multiple employer trustee basis); policy number; policy effective date; provision for the entire contract to include applications, the certificate of insurance and any attached riders; workers' compensation disclaimer notice; description of the policy in bold type as the Group Small Employer Preventive and Primary Care Benefit Plan, the Group Small Employer In-Hospital Benefit Plan or the Group Small Employer Standard Health Benefit Plan; and the form number. The Group Policy Face Pages for the prototype policies include a:

(i) Group Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 SE.PP) for a single employer policy;

(ii) Group Small Employer In-Hospital Benefit Plan (Form Number 2055 SE.IH) for a single employer policy;

(iii) Group Small Employer Standard Health Benefit Plan (Form Number 2055 SE.STD) for a single employer policy;

(iv) Group Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 MET.PP) for a multiple employer trustee policy;

(v) Group Small Employer In-Hospital Benefit Plan (Form Number 2055 MET.IH) for a multiple employer trustee policy;

(vi) Group Small Employer Standard Health Benefit Plan (Form Number 2055 MET.STD) for a multiple employer trustee policy;

(vii) Group Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 ASSN.PP) for an association policy;

(viii) Group Small Employer In-Hospital Benefit Plan (Form Number 2055 ASSN.IH) for an association policy;

(ix) Group Small Employer Standard Health Benefit Plan (Form Number 2055 ASSN STD) for an association policy.

(B) The individual policy face pages are described in this subparagraph. These prototype policies provide for the entire contract to include the application and any attached papers. If the small employer carrier elects to use policies other than the prototype forms, this shell format shall be used with any small employer health benefit plan. All policy face pages, whether or not the prototype form is used, shall include the small employer carrier name and address; renewal statement; right to change premium rates statement; Policyholder (Employee) name and address; policy number; the policy effective date; provision for the entire contract to include the application and any attached papers; right to examine policy provision; workers' compensation disclaimer notice; description of the policy in bold type as the Individual Small Employer Preventive and Primary Care Benefit Plan, the Individual Small Employer In-Hospital Benefit Plan, or the Individual Small Employer Standard Health Benefit Plan; and the form number These prototype policies require the plans to be issued on a guaranteed renewable for life or attainment of the maximum benefits, if any, basis. If the prototype policy forms are not used, a small employer carrier shall issue small employer health benefit plans on a guaranteed renewable for life or attainment of maximum benefits basis; or on a guaranteed renewable basis with the only reasons for termination being those set out in the Insurance Code, Articles 26.23 and 26.24A and shall include a conversion provision which provides conversion options required under Subchapter F of Chapter 3 of this title (relating to Group Health Insurance Mandatory Conversion Privilege). The Individual Policy Face Pages include the following:

(i) Individual Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 ISE.PP);

(ii) Individual Small Employer In-Hospital Benefit Plan (Form Number 2055 ISE.IH);

(iii) Individual Small Employer Standard Health Benefit Plan (Form Number 2055 ISE.STD).

(2) The Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures form (Form Number TOLLFREE) for group and individual policies are described in this paragraph. This prototype form contains the language prescribed in §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures) and shall be attached as the second or third page of the policy and the certificate of insurance. The variable provisions are optional only to the extent outlined in §1.601 of this title.

(3) The group certificate of insurance face page is described in this paragraph. Each certificate of insurance face page, whether or not the prototype form is used, shall include the small employer carrier name and address; the certification provision; a provision that the certificate face page, all attached provisions and any riders shall constitute the entire certificate of insurance; the workers' compensation disclaimer notice; a description of the plan in bold type as the Small Employer Preventive and Primary Care Benefit Plan, the Small Employer In-Hospital Benefit Plan or the Small Employer Standard Health Benefit Plan; and the form number. The identification information (Employee name, ID Number, Certificate Effective Date, Policyholder name, Policy Number, Policy Effective Date) is variable to the extent that small employer carriers may include all of the information in the certificate of insurance by any appropriate method, such as an insert or as a sticker on the face page or schedule of benefits or printed on the face page as provided in the prototype form. The variable replacement provision is an optional provision which carriers may include as provided in the prototype form or carriers may alter the language in any appropriate manner or may elect to omit the provision in its entirety. The Group Certificate of Insurance Face Pages include the following:

(A) Certificate of Insurance Face Page for the Group Small Employer Preventive and Primary Care Benefit Plan (Form Number 2055 CERT.PP);

(B) Certificate of Insurance Face Page for the Group Small Employer In-Hospital Benefit Plan (Form Number 2055 CERT.IH);

(C) Certificate of Insurance Face Page for the Group Small Employer Standard Health Benefit Plan (Form Number 2055 CERT.STD).

(4) The data page for individual policies (Form Number 2055 DP) is described in this paragraph. The Premium, Premium Mode, Policy Fee and Dependent Coverage information shall be included in the policy whether or not the prototype Data Page is used. The Dependent Coverage information is variable to allow small employer carriers to insert the appropriate information or if dependent coverage is not elected, the provision may be omitted. The Policy Fee provision shall be omitted if there is no policy fee. The information on this Data Page may be included by any appropriate method, such as an insert as provided by the prototype form, or as a sticker on the face page or the schedule of

benefits page or printed on the face page or schedule of benefits page.

(5) The table of contents for group policies (Form Number 2055 TCG) and table of contents for individual policies (Form Number 2055 TCI) are described in this paragraph. The variable items shall be included or omitted as appropriate for the policy or certificate and page numbers shall be renumbered accordingly. If the prototype Table of Contents is not used, the format and order shall be the same as provided in the prototype.

(6) The General Provisions form for group policies (Form Number 2055 GGP) may be used with all group small employer health benefit plans. If the prototype General Provisions form is not used, each general provision with same or similar language shall be included in each policy/certificate. Variable language for the General Provisions form are described in the following subparagraphs.

(A) The definition of an Eligible Employee under the Eligibility for Coverage (Employee Coverage) provision shall add that an "Eligible Employee also includes an employee of an Employer member of an association" when the policy is to be issued to an association.

(B) The Initial Enrollment for New Eligible Employees provision under Effective Dates allows a variable for a waiting period which is to be included if the small employer requires a waiting period or omitted if not applicable. The length of time for the waiting period is also variable to allow flexibility for small employers to elect a period of time not to exceed 90 days.

(C) The Newborn Children provision under Effective Dates allows a variable to be included if the small employer carrier requires a premium to be charged for the 31 day period of coverage if the insured person elects not to continue coverage for the newborn child If no premium will be charged, this provision shall be omitted.

(D) The Late Enrollees provision under Effective Dates shall include one of the 4 variable provisions to reflect the date on which a late enrollee will be eligible for coverage.

(E) The pre-existing Conditions provision is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, this provision shall be included in its entirety.

(F) The Eligible Employees and Dependents provisions under Termination of Insurance allow variables for continued coverage for an employee who is on an approved leave of absence for a specified period of time to be inserted if the provision remains. This provision shall be included or omitted as appropriate.

(G) The Eligible Employees and Dependents provisions under Termination of Insurance allow variables for coverage to end on either "the date the Employer terminates participation in the Trust" which may be included when the policy is to be issued to a multiple employer trust; or "the date the Employer member terminates membership in the Association" which may be included when the policy is to be issued to an association.

(H) The Policyholder and Company provision under Termination of Insurance provides alternate provisions for termination by the Employer as Policyholder; termination by the Association as Policyholder; termination of participation by an Employer (member) under an Association policy, or termination of participation by an Employer under a Multiple Employer Trust policy. Provisions shall be included appropriately for a single employer policy, an association policy or a multiple employer trust policy.

(I) The Policyholder and Company provision under Termination of Insurance allows a variable to be included for the exception to non-payment of premiums if a grace period is provided. If a grace period is not provided, the variable "Coverage will end at the end of the last period for which premium payment has been made to Us" shall be included. A variable is allowed to be included if the small employer carrier will terminate the employer's plan for failure to maintain the required minimum participation requirements. A variable is allowed to be included if the small employer carrier will terminate the employer's plan due to failure of the employer to maintain status as a small employer, as described in §26.5 of this title (relating to Applicability and Scope).

(7) The General Provisions for individual policies (Form Number 2055 IGP) may be used with all individual small employer health benefit plans. If the prototype General Provisions form is not used, each general provision with same or similar language shall be included in each policy. Variable provisions for the General Provisions form include the following.

(A) The Initial Enrollment for New Eligible Employees provision under Effective Dates allows a variable for a waiting period which is to be included if the small employer requires a waiting period or omitted if not applicable. The length of time for the waiting period is also variable to allow flexibility for small employers to elect a period of time not to exceed 90 days

(B) The Newborn Children provision under Effective Dates provides a variable to be included if the small employer carrier requires a premium to be charged for the 31 day period of coverage if the insured person elects not to continue coverage for the newborn child. If no premium will be charged, this provision shall be omitted.

(C) The Late Enrollees provision under Effective Dates shall include one of the 4 variable provisions to reflect the date on which a late enrollee will be eligible for coverage.

(D) The pre-existing Conditions provision is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, this provision shall be included in its entirety.

(8) The Group Provisions form (Form Number 2055 GRP) may be used with all group small employer health benefit plans. If the prototype Group Provisions form is not used, each provision with the same or similar language shall be included in each policy/certificate. Variable provisions for the Group Provisions form include the following:

(A) a variable is provided in the Payment of Premiums provision for the mode of premium to be inserted;

(B) the Representations provision under Time Limit on Certain Defenses shall provide that statements made by the "Policyholder or" Employer shall be considered representations and not warranties and that the "Policyholder or" Employer shall be provided a copy of any statements used to contest coverage when policies are to be issued to a multiple employer trust or to an association;

(C) the Time Limit on Certain Defenses provision allows a variable for pre-existing Conditions only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing condi-

tions. If a pre-existing condition limitation applies, this provision shall be included in its entirety;

(D) the Payment to Assignee provision under Payment of Claims is variable only to the extent that Chapter 20 companies may substitute this provision for the alternate Assignment provision;

(E) the Grace Period provision is a variable to be included when a grace period is provided for the specified number of days as determined by the small employer carrier;

(F) Dividends, Subrogation and Right to Recovery/Clerical Error provisions may be included, omitted or modified by the small employer carrier. Right to Recovery/Clerical Error provisions shall be considered one provision for purposes of variability and both provisions shall be either included or omitted.

(9) The Individual Provisions form (Form Number 2055 IRP) may be used with all individual small employer health benefit plans. If the Individual Provisions prototype form is not used, a provision with the same or similar language shall be used in each policy. Variable provisions for the Individual Provisions form include the following

(A) The Time Limit on Certain Defenses provision allows a variable for pre-existing Conditions only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, this provision shall be included in its entirety.

(B) The Payment to Assignee provision under Payment of Claims is variable only to the extent that Chapter 20 companies may substitute this provision for the Assignment provision.

(C) The Cancellation, Dividends, Misstatement of Age, Right to Recovery, Subrogation, and Unpaid Premiums provisions may be included, omitted or modified by the small employer carrier.

(h) Prescribed benefits are discussed in this subsection. No policy, subscriber contract, or certificate shall be issued or delivered for issue in this state to a small employer by a small employer carrier as a Preventive and Primary Care Benefit Plan, an In-Hospital Benefit Plan or a Standard Health Benefit Plan unless such policy, subscriber contract, or certificate contains the prescribed benefit provisions outlined in paragraphs (1)-(4) of this subsection.

(1) The Preventive and Primary Care Benefit Plan is discussed in this paragraph. The following forms shall be included in this plan as prescribed. Variable language in the prescribed forms is indicated by brackets.

(A) The Schedule of Benefits (Non-PPO Plan) for the Preventive and Primary Care Benefit Plan (Form Number 2055 SCH.PP) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits.

(i) Variable amounts of $100 or $250 for the Policy Year Deductible are allowed to be elected by the small employer carrier or offered as an option to the small employer.

(ii) The optional Prescription Drug Benefit Rider shall be included on the Schedule of Benefits when provided. This optional rider is allowed to be included with the Preventive and Primary Care Benefit Plan. The prescription drug benefit shall be provided at a Percentage Payable of at least 50%, but may be provided at a greater Percentage Payable. The small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a deductible not to exceed $8.00 per prescription or refill for a generic drug and $12.00 per prescription or refill for a name brand drug.

(B) The Schedule of Benefits (PPO Plan) for the Preventive and Primary Care Benefit Plan (Form Number 2055 SCHPO PP) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan includes preferred provider (PPO) benefits.

(i) The terms "Policy Year Deductible", "Non-Preferred Provider Policy Year Deductible" and "Preferred Provider Policy Year Deductible" are variable to allow the same policy year deductible to apply to both preferred and non-preferred provider options or to allow a "Non-Preferred Provider Policy Year Deductible" and a "Preferred Provider Policy Year Deductible" if different deductibles will apply. A "Per Visit Deductible" may be used in lieu of a Preferred Provider Policy Year Deductible. The deductible may be waived for either option.

(ii) A variable amount of $100 or $250 for the Policy Year Deductible or the Non-Preferred Provider Policy Year Deductible may be elected by the small employer carrier or the small employer. The Preferred Provider Policy Year Deductible may be any lesser amount.

(iii) A Per Visit Deductible of $10 or $15 may be included for the preferred provider option except for the Preventive Care Benefit.

(iv) A variable Percentage Payable of 90% or 100% when preferred providers are utilized shall be determined by the small employer carrier or offered as an option to the small employer. The Percentage Payable for the Preventive Care Benefit is not variable and shall be 100%

(v) The optional Prescription Drug Benefit Rider shall be included on the Schedule of Benefits when provided. This optional rider is allowed to be included with the Preventive and Primary Care Benefit Plan. The prescription drug benefit shall be provided at a Percentage Payable of at least 50%, but may be provided at a greater Percentage Payable. The small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a deductible not to exceed $8.00 per prescription or refill for a generic drug and $12 00 per prescription or refill for a name brand drug.

(C) The Policy Definitions for the Preventive and Primary Care Benefit Plan (Form Number 2055 DEF.PP) shall be in the language and format prescribed.

(i) The term and definition "Certificate of Insurance" is variable to be included or omitted as appropriate.

(ii) The terms and definitions for "Contracting Facility" and "Noncontracting Facility" are variable for Chapter 20 companies only and neither provision shall be included by other than Chapter 20 companies.

(iii) The term and definition of "Employer" provide a variable to include an Employer member of an association when a policy is to be issued to an association.

(iv) The term and definition of "Policyholder" shall be included in the Policy Definitions as appropriate to define the Policyholder as the Employer, the Trustee of a Multiple Employer Trust or the Association.

(v) The alternate definitions for the term "Policy Year" are included to allow the small employer to select the definition that is consistent with the carrier's and employer's practices. The definition, as selected, shall be included in the policy/certificate.

(vi) The term and definition of "pre-existing Condition" is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-

existing conditions. If a pre-existing condition limitation applies, this provision shall be included in its entirety.

(D) The Benefits Provided for the Preventive and Primary Care Benefit Plan (Form Number 2055 BEN.PP) shall be in the language and format prescribed.

(E) The Exclusions and Limitations for the Preventive and Primary Care Benefit Plan (Form Number 2055 EXC.PP) shall be in the language and format prescribed. Variable exclusions are allowed to be included by Chapter 20 companies only.

(F) The Prescription Drug Benefit Rider (Form Number 2055 PDR), if elected, shall be in the language and format prescribed. This optional rider is allowed with the Preventive and Primary Care Benefit Plan. The variable 50% may be changed to provide a greater percentage payable under this rider.

(2) This paragraph discusses the in-hospital benefit plan. The following forms shall be included in this plan as prescribed. Variable language in the prescribed forms is indicated by brackets.

(A) The Schedule of Benefits (Non-PPO Plan) for the In-Hospital Benefit Plan (Form Number 2055 SCH.IH) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits.

(i) A variable amount of $100 or $250 for the Hospital Deductible Per One Period of Hospital Confinement may be selected by the small employer carrier or offered as an option to the small employer.

(ii) A variable amount of $2,000 or $5,000 per individual for the Policy Year Copayment Maximum may be selected by the small employer carrier or offered as an option to the small employer.

(iii) The optional Supplementary Accidental Injury Benefit shall be included on the Schedule of Benefits when elected. This optional rider is allowed with the In-Hospital Benefit Plan.

(B) The Schedule of Benefits (PPO Plan) for the In-Hospital Benefit Plan (Form Number 2055 SCHPO.IH) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan includes preferred provider (PPO) benefits.

(i) The terms "Hospital Deductible Per One Period of Hospital Confinement," "Hospital Preferred Provider Deductible Per One Period of Hospital Confinement" and "Hospital Non-Preferred Provider Deductible Per One Period of Hospital Confinement" are variable to allow the same hospital deductible per confinement to apply to both preferred and non-preferred options or to allow a Hospital Preferred Provider Deductible Per One Period of Hospital Confinement and a Hospital Non-Preferred Provider Deductible Per One Period of Hospital Confinement if different deductibles will apply. The deductible may be waived for either option.

(ii) A variable amount of $100 or $250 for the Hospital Deductible Per One Period of Hospital Confinement or the Hospital Non-Preferred Provider Deductible Per One Period of Hospital Confinement may be elected by the small employer carrier or offered as an option to the small employer.

(iii) A variable amount of $2,000 or $5,000 per individual for the Policy Year Copayment Maximum may be elected by the small employer carrier or offered as an option to the small employer A combination of preferred provider and non-preferred provider amounts for the Policy Year Copayment Maximum may be provided.

(iv) A variable Percentage Payable of 90% or 100% for the Inpatient Hospital Expense Benefit and Outpatient Follow-Up Care Benefit and a variable Percentage Payable of 70% or 80% for Mental Illness or Chemical Dependency Benefits when preferred providers are utilized shall be determined by the small employer carrier or offered as an option to the small employer

(v) A variable Percentage Payable of 70% or 80% for the Inpatient Hospital Expense Benefit and Outpatient Follow-Up Care Benefit when non-preferred providers are utilized shall be determined by the small employer carrier or offered as an option to the small employer.

(vi) The optional Supplementary Accidental Injury Benefit shall be reflected on the Schedule of Benefits, when the optional rider is elected with the In-Hospital Benefit Plan.

(C) The Schedule of Benefits (Non-PPO Plan) for the Preventive and Primary Care Benefit Rider (Form Number 2055 SCH.PPR) shall be added to the In-Hospital Benefit Plan, when elected, in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits Variable amounts of $100 or $250 for the Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer.

(D) The Schedule of Benefits (PPO Plan) for the Preventive and Primary Care Benefit Rider (Form Number 2055 SCHPO.PPR) shall be added to the In-Hospital Benefit Plan, when elected, in the language and format prescribed. This Schedule of Benefits shall be used when the plan includes preferred provider (PPO) benefits.

(i) The terms "Policy Year Deductible", "Non-Preferred Provider Policy Year Deductible" and "Preferred Provider Policy Year Deductible" are variable to allow the same policy year deductible to apply to both preferred and non-preferred provider options or to allow a "Non-Preferred Provider Policy Year Deductible" and a "Preferred Provider Policy Year Deductible" if different deductibles will apply. A "Per Visit Deductible" may be used in lieu of a Preferred Provider Policy Year Deductible. The deductible may be waived for either option.

(ii) A variable amount of $100 or $250 for the Policy Year Deductible or the Non-Preferred Provider Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer. The Preferred Provider Policy Year Deductible may be any lesser amount.

(iii) A Per Visit Deductible of $10 or $15 may be included for the preferred provider option except for the Preventive Care Benefit.

(iv) A variable Percentage Payable of 90% or 100% when preferred providers are utilized shall be determined by the small employer carrier or offered as an option to the small employer. The Percentage Payable for the Preventive Care Benefit is not variable and shall be 100%

(E) The Policy Definitions for the In-Hospital Benefit Plan (Form Number 2055 DEF.IH) shall be in the language and format prescribed.

(i) The term and definition "Certificate of Insurance" is variable to be included or omitted as appropriate.

(ii) The terms and definitions for "Contracting Facility" and "Noncontracting Facility" are variable to be included by Chapter 20 companies only and neither provision shall be included by other than Chapter 20 companies.

(iii) The term and definition of "Employer" provide a variable to include an Employer member of an association when a policy is to be issued to an Association.

(iv) The term "One Period of Hospital Confinement" provides a

variable number of days of 90, 120, 150,, or 180 to be included as elected by the small employer carrier or the small employer to determine one period of hospital confinement.

(v) The term and definition of "Policyholder" shall be included in the Policy Definitions as appropriate to define the Policyholder as the Employer, the Trustee of a Multiple Employer Trust or the Association.

(vi) The alternate definitions for the term "Policy Year" are included to allow the small employer carrier to select the definition that is consistent with the carrier's and employer's practices. The definition, as selected, shall be included in the policy/certificate.

(vii) The term and definition of "pre-existing Condition" is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, this provision shall be included in its entirety.

(F) The Benefits Provided for the In-Hospital Benefit Plan (Form Number 2055 BEN.IH) shall be in the language and format prescribed. The Individual Policy Year Copayment Maximum amount of $2,000 or $5,000 elected shall be inserted in this provision

(G) The Exclusions and Limitations for the In-Hospital Benefit Plan (Form Number 2055 EXC.IH) shall be in the language and format prescribed. Variable exclusions are allowed to be included by Chapter 20 companies only.

(H) The Supplementary Accidental Injury Benefit Rider for the In-Hospital Benefit Plan (Form Number 2055 ACCR) shall be in the language and format prescribed. This optional rider is allowed with the In-Hospital Benefit Plan.

(I) The Preventive and Primary Care Benefit Rider (Form Number 2055 PPR) added to the In-Hospital Benefit Plan shall be in the language and format prescribed. This optional rider is allowed with the In-Hospital Benefit Plan.

(3) The standard health benefit plan is discussed in this paragraph. The following forms shall be included in this plan as prescribed. Variable language in the prescribed forms is indicated by brackets.

(A) The Schedule of Benefits (Non-PPO Plan) for the Standard Health Benefit Plan (Form Number 2055 SCH.STD) shall be in the language and format prescribed. This Schedule of Benefits shall be used when the plan does not include preferred provider (PPO) benefits.

(i) A variable amount of $250 or $500 for the Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer.

(ii) A variable amount of $2,000 per individual or $5,000 per individual for the Policy Year Copayment Maximum may be elected by the small employer carrier or offered as an option to the small employer.

(iii) A variable amount of $6,000 per family or $15,000 per family for the Policy Year Copayment Maximum may be elected by the small employer carrier or offered as an option to the small employer.

(iv) The variable limitation of a lifetime maximum of three separate series of treatment for each insured person for Chemical Dependency benefits shall be reflected when the small employer carrier elects to include this limitation.

(v) The Prescription Drug Benefit is variable only to the extent that the Percentage Payable may be greater than 50% or the small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a deductible not to exceed $8.00 per prescription or refill for a generic drug and $12.00 per prescription or refill for a name brand drug.

(vi) All benefits added by riders shall be reflected on the Schedule of Benefits.

(B) The Schedule of Benefits (PPO Plan) for the Standard Health Benefit Plan (Form Number 2055 SCHPO.STD). This Schedule of Benefits shall be used when the plan includes preferred provider (PPO) benefits.

(i) The terms "Policy Year Deductible," "Non-Preferred Provider Policy Year Deductible" and "Preferred Provider Policy Year Deductible" are variable to allow the same policy year deductible to apply to both preferred and non-preferred provider options or to allow a "Non-Preferred Provider Policy Year Deductible" and a "Preferred Provider Policy Year Deductible" if different deductibles will apply. A "Per Visit Deductible" may be used in lieu of any policy year deductible. The deductible may be waived for either option.

(ii) A variable amount of $250 or $500 for the Policy Year Deductible or the Non-Preferred Provider Policy Year Deductible may be elected by the small employer carrier or offered as an option to the small employer. The Preferred Provider Policy Year Deductible may be any lesser amount.

(iii) A Per Visit Deductible of $10 or $15 is allowed except for the Preventive Care Benefit.

(iv) A variable amount of $2,000 per individual or $5,000 per individual for the Policy Year Copayment Maximum may be elected by the small employer carrier or offered as an option to the small employer. The preferred provider and non-preferred provider amounts may be combined for the Policy Year Copayment Maximum.

(v) A variable amount of $6,000 per family or $15,000 per family for the Policy Year Copayment Maximum may be elected by the small employer carrier or the small employer. The preferred provider and non-preferred provider amounts may be combined for the Policy Year Copayment Maximum.

(vi) A variable Percentage Payable of 90% or 100% when preferred providers are utilized shall be determined by the small employer carrier. The Percentage Payable for the Preventive Care Benefit is not variable and shall be 100% with no deductible.

(vii) A variable Percentage Payable of 70% or 80% when non-preferred providers are utilized shall be determined by the small employer carrier. The Percentage Payable for Preventive Care Benefits is not variable and shall be at 100% with no deductible.

(viii) The variable limitation of a lifetime maximum of three separate series of treatments for each insured person for Chemical Dependency benefits shall be reflected when the small employer carrier elects to include this limitation.

(ix) The Prescription Drug Benefit is variable only to the extent that the Percentage Payable may be greater than 50% or the small employer carrier may elect to provide the prescription drug benefit through a prescription drug card program with a deductible not to exceed $8.00 per prescription or refill for a generic drug and $12.00 per prescription or refill for a name brand drug.

(x) Any benefits added by riders shall be reflected on the Schedule of Benefits.

(C) The Policy Definitions for the Standard Health Benefit Plan (Form Number 2055 DEF.STD) shall be in the language and format prescribed.

(i) The term and definition "Certificate of Insurance" is variable to

be included or omitted as appropriate.

(ii) The terms and definitions for "Contracting Facility" and "Noncontracting Facility" are variables to be included by Chapter 20 companies only and neither provision shall be used by other than Chapter 20 companies.

(iii) The term and definition of "Employer" provides a variable to include an Employer member of an association when a policy is to be issued to an Association

(iv) The term and definition of "Policyholder" shall be included in the Policy Definitions as appropriate to define the Policyholder as the Employer, the Trustee of a Multiple Employer Trust or the Association.

(v) The alternate definitions for the term "Policy Year" are included to allow the small employer carrier to select the definition that is consistent with the carrier's and employer's practices The definition, as selected, shall be included in the policy/certificate.

(vi) The term and definition of "pre-existing Condition" is variable only to the extent that it may be omitted in its entirety if the small employer carrier elects not to impose a limitation for pre-existing conditions. If a pre-existing condition limitation applies, the provision shall be included in its entirety.

(D) The Benefits Provided for the Standard Health Benefit Plan (Form Number 2055 BEN.STD) shall be in the language and format prescribed.

(i) The Individual Policy Year Copayment Maximum amount elected shall be inserted in this provision.

(ii) The Family Policy Year Copayment Maximum elected shall be inserted in this provision.

(E) The Exclusions and Limitations for the Standard Health Benefit Plan (Form Number 2055 EXC.STD) shall be in the language and format prescribed. Variable exclusions may be included by Chapter 20 companies only.

(F) The Alternate Benefits for Chemical Dependency (Form Number 2055 ACD), if elected by the small employer carrier, shall be attached to the policy, subscriber contract and certificate and shall be in the language and format prescribed

(4) Forms common to more than one health benefit plan are described in subparagraphs (A)-(D) and shall be included with the benefit provisions of each plan as specified

(A) Alternate Cost Containment Provisions for Large Case Management and Second Opinion Requirements (Form Number 2055 ACC) are provided as optional provisions for all plans. Small employer carriers may use these provisions or modification of these provisions. Other alternate cost containment provisions, including precertification, pre-authorization, case management and utilization review may be used.

(B) The Continuation/Conversion Provisions (Form Number 2055 COP) shall be included with all group plans. This form shall be in the language and format prescribed

(C) The Coordination of Benefits (Form Number 2055 COB) shall be included with all plans This form shall be in the language and format prescribed. The variable insert language "This provision will only apply for the duration of your employment with the Employer" is required to be included in the individual policies

(D) The Preferred Provider Provisions (PPO) (Form Number 2055 PPO) shall be included with all plans when preferred provider options are included. This form shall be in the language and format prescribed. Additional provisions may be added as necessary to disclose preferred provider information.

(i) Variable provisions are allowed for the definition of service area to be in terms of counties, zip codes, in terms of a 50 mile radius from the employee's principal place of employment unless there are no providers located within the 50 mile radius, or the service area may be described in a specific document to be referenced in the policy/certificate provision. Service areas by zip codes shall be defined in a non-discriminatory manner and in compliance with the Insurance Code, Article 21.21, §4, and Article 21.21-5. Service area definitions and descriptions shall be filed with the form filings The small employer carrier shall obtain approval for any definition of the service area by counties or zip codes where the grouping of counties or zip codes exceed a 50 mile radius from the principal place of employment or for a different definition of a service area.

(ii) Except as provided in §26.21 of this title (relating to Cost Containment), preferred provider arrangements shall comply with Subchapter X of Chapter 3 of this title (relating to Preferred Provider Plans).

(E) The Chemical Dependency Benefit Waiver Rider (Form Number 2055 CDW) shall be in the language and format prescribed. The Rider may be included with the Preventive and Primary Care Benefit Plan or the Standard Health Benefit Plan when at least 50 percent of the employees waive alcohol and substance abuse benefits in writing, and indicate in writing that they have undergone treatment or counseling for alcoholism or substance abuse within the last three years. The Rider shall apply only to those employees who have waived these benefits in writing as noted in this subparagraph. Small employer carriers shall comply with the provisions of the Insurance Code, Article 26. 47A, before the above waiver is attached to a policy, subscriber contract and certificate. The small employer carrier shall obtain in writing a waiver of alcohol and substance abuse benefits by at least 50% of the employees and the employees shall indicate in writing that they have undergone alcoholism or substance abuse treatment or counseling within the last three years.

(5) Applications are discussed in this paragraph. Small employer carriers may use any appropriate application, enrollment, or participation agreement forms. A notice shall be required on all application, enrollment, or participation agreement form that the appropriate application or enrollment form must be received by the small employer carrier not later than the 31st day after the date on which employment begins even if the employer requires a waiting period before the employee is eligible for coverage.

(6) The outline of coverage is discussed in this paragraph. No individual small employer health benefit plan, subject to the Insurance Code, Chapter 26, may be delivered or issued for delivery in this state unless an appropriate Outline of Coverage, as prescribed in the Insurance Code, Article 3.70-1(G), and §3.3090 of this title (relating to Outline of Coverage Generally), §3.3092 of this title (relating to Format, Content, and Readability for Outline of Coverage), and §3.3093 of this title (relating to Prescribed Outlines of Coverage), or this paragraph is also issued If the prototype forms are not used, small employer carriers must follow instructions outlined in §§3 3090, 3.3092, and 3 3093, as applicable.

(A) The Outline of Coverage for the Small Employer Preventive and Primary Care Benefit Plan (Non-PPO) (Form Number 2055 OC.PP) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in paragraph (1)(A) and (E) of this subsection.

(B) The optional insert to the Outline of Coverage shall be included when the Prescription Drug Rider (Form Number 2055 OC.PDR) is elected. The Prescription Drug Rider is allowed to be added to the Preventive and Primary Care Benefit Plan (Non-PPO and PPO). The variables in the Benefits provision correspond to the variables described for the Schedule of Benefits in paragraph (1)(A) of this subsection.

(C) The Outline of Coverage for the Small Employer Preventive and Primary Care Benefit Plan (PPO), (Form Number 2055 OCPO.PP) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits in paragraph (1)(B) and (E) of this subsection.

(D) The Outline of Coverage for the Small Employer In-Hospital Benefit Plan (Non-PPO) (Form Number 2055 OC.IH) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in paragraph (2)(A) and (G) of this subsection.

(E) Optional insert to the Outline of Coverage shall be included when the Supplementary Accidental Injury Benefit (Form Number 2055 OC. ACCR) is elected. The Supplementary Accidental Injury Benefit is allowed to be added to the In-Hospital Benefit Plan (Non-PPO and PPO).

(F) Optional insert to the Outline of Coverage shall be included when the Preventive and Primary Care Benefit Rider (Form Number 2055 OC.PPR) is elected. The Preventive and Primary Care Benefit Rider is allowed to be added to the In-Hospital Benefit Plan (Non-PPO). The variables in the Benefits provision correspond to the variables described for the Schedule of Benefits in paragraph (2)(C) of this subsection.

(G) The Outline of Coverage for the Small Employer In-Hospital Benefit Plan (PPO) (Form Number 2055 OCPO. IH) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in paragraph (2)(B) and (E) of this subsection.

(H) Optional insert to the Outline of Coverage shall be included when the Preventive and Primary Care Benefit Rider (Form Number 2055 OCPO.PPR) is elected. The Preventive and Primary Care Benefit Rider is allowed to be added to the In-Hospital Benefit Plan (PPO). The variables in the Benefits provision correspond to the variables described for the Schedule of Benefits in paragraph (2)(D) of this subsection.

(I) The Outline of Coverage for the Small Employer Standard Health Benefit Plan (Non-PPO) (Form Number 2055 OC.STD) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in paragraph (3)(A) and (E) of this subsection.

(J) The Outline of Coverage for the Small Employer Standard Health Benefit Plan (PPO) (Form Number 2055 OCPO.STD) is discussed in this subparagraph. The variables in the Benefits and Exclusions and Limitations provisions correspond to the variables described for the Schedule of Benefits and Exclusions and Limitations in paragraph (3)(B) and (E) of this subsection.

(j) The HMO forms are discussed in this subsection.

(1) Prototype contracts/certificates of coverage and benefit plans have been developed to facilitate implementation of the the Insurance Code, Chapter 26 and to streamline the contract approval process. The required benefit language is provided in the prototype Primary and Preventive Health Benefit Plan (Form Number 2055 HMO-PP), and the Standard Health Benefit Plan (Form Number 2055 HMO-STAN). The optional standard provision language is provided in the prototype contract/certificate of coverage (Form Number 2055 HMO-CONT)

(2) The prototype contracts/certificates of coverage provide for the entire contract to include any applications, certificate of coverage and any attached riders.

(3) If the HMO elects to be a small employer carrier and offers a health benefit plan other than the two prototype benefit plans; that plan must be a state approved health benefit plan that complies with the requirements of Title XI, Public Health Service Act (42 United States Code, §300, et seq) and the rules adopted under the act. The following content format shall be used:

A. CONTRACT FACE PAGE This page shall contain the name, address and telephone numbers (800 number, if applicable) of the health maintenance organization. The prototype contract shall be entitled:

Texas Small Employer Group Health Benefit Plan
Contract/Certificate of Coverage

The attached benefit plan shall be entitled one of the following:

1. **Preventive and Primary Care Benefit Plan, or**
2. **Standard Health Benefit Plan**

B. TOLL-FREE NUMBER PAGE This form must contain the language prescribed in <*>1.601 of Chapter 1 of this title (relating to Notice of Toll-free Telephone Numbers and Information and Complaint Procedures) and shall be attached as the first, second or third page of the contract.

C. CONTRACT PROVISIONS At a minimum, the contract must contain the following provisions:

1. Face Page
2. Benefits
3. Cancellation

4. Claim filing procedure
5. Complaint procedure
6. Conformity with state law
7. Continuation of coverage for certain dependents
8. Conversion privilege
9. Coordination of Benefits
10. Definitions
11. Effective date
12. Eligibility
13. Emergency services
14. Entire contract provision
15. Exclusions and limitations
16. Grace period
17. Incontestability
18. Schedule of charges
19. Service area
20. Subrogation
21. Termination

D. RIDERS Riders allowing for additional benefits may be attached to the state approved health benefit plan. The **Preventive and Primary Care Benefit Plan** may allow the attachment of a prescription drug rider only. The **Standard Health Benefit Plan** may allow the attachment of unlimited riders.

§26.15.Additional Coverage

(a) An eligible employee may obtain coverage in addition to coverage purchased by the employer if at least 40% of the eligible employees elect to obtain the same additional coverage. Subject to insurability, any number of eligible employees may otherwise obtain coverage in addition to coverage purchased by the employer. The additional coverage may be paid for by the employer, the employee, or both.

(1) When an employer selects the preventive and primary care benefit plan, additional coverage may only be provided through a separate policy or certificate, as applicable, or a different small employer health benefit plan, except in the case of a rider providing coverage of prescription drugs. No other riders may be included with the preventive and primary care benefit plan.

(2) When an employer selects the in-hospital benefit plan, additional coverage may only be provided through a separate policy or certificate, as applicable, or a different small employer health benefit plan, except in the case of a rider providing coverage for preventive and primary care or a supplementary accident benefit plan. No other riders or supplementary benefit plans may be included with the in-hospital benefit plan.

(3) When an employer selects the standard health benefit plan, additional coverage may be provided through riders, supplementary benefit plans, or separate policies or certificates, as applicable.

(b) Additional coverage does not include life insurance and annuity benefits.

(c) A health carrier shall not be required to provide any type of additional coverage which the carrier does not write or offer in this state.

§26.16. Renewability of Coverage and Cancellation.

(a) Except as provided by the Insurance Code, Article 26.24, a small employer carrier shall renew any small employer health benefit plan for any covered small employer at the option of the small employer, except for:

(1) nonpayment of a premium as required by the terms of the plan;

(2) fraud or misrepresentation of a material fact by the small employer;

(3) noncompliance with small employer health benefit plan provisions. Such provisions may address requirements such as the level of contribution and participation and failure of an employer to maintain status as a small employer subject to requirements of this chapter. Noncompliance with a small employer health benefit plan with respect to an HMO also includes those items set forth in §11.506(4)(A) of this title (relating to Mandatory Provisions: Group and Non-Group Agreement and Group Certificate).

(b) A small employer carrier may refuse to renew the coverage of an eligible employee or dependent for fraud or misrepresentation of a material fact by that individual.

(c) A small employer carrier may not cancel a small employer health benefit plan except for the reasons specified for refusal to renew under the Insurance Code, Article 26.23(a), and subsections (a) and (b) of this section. A small employer carrier may not cancel the coverage of an eligible employee or dependent except for the reasons specified for refusal to renew under the Insurance Code, Article 26. 23(b), and subsections (a) and (b) of this section.

(d) Standard benefit plans, provided through an individual policy, shall be guaranteed renewable for life or until maximum benefits have been paid. Other small employer health benefit plans, provided

through individual policies, shall be guaranteed renewable for life or until maximum benefits have been paid, or may be guaranteed renewable with the only reasons for termination being those set out in the Insurance Code, Articles 26.23 and 26. 24, and this chapter, provided that such plans shall include a conversion provision which provides comparable benefits to those required under Subchapter F of Chapter 3 of this title (relating to Group Health Insurance Mandatory Conversion Privilege). All other health benefit plans issued to small employers shall be renewed at the option of the small employer, but may provide for termination in accordance with the Insurance Code, Chapter 26, and this chapter.

§26.17. Refusal to Renew and Application to Reenter Small Employer Market.

(a) A small employer carrier may elect to refuse to renew each small employer health benefit plan delivered or issued for delivery by the small employer carrier in this state or in a geographic service area approved under the Insurance Code, Article 26.22. The small employer carrier must notify the commissioner of the election not later than the 180th day before the date coverage under the first small employer health benefit plan terminates under the the Insurance Code, Article 26.24(a).

(b) The small employer carrier must notify each affected covered small employer not later than the 180th day before the date on which coverage terminates for that small employer.

(c) A small employer carrier that elects under the Insurance Code, Article 26.24(a), to refuse to renew all small employer health benefit plans in this state or in an approved geographic service area may not write a new small employer health benefit plan in this state or in the geographic service area, as applicable, before the fifth anniversary of the date of notice to the commissioner under the Insurance Code, Article 26.24(a).

(d) A small employer carrier that elects not to renew under the Insurance Code, Article 26.24 and this section may not resume offering health benefit plans to small employers in this state or in the geographic area for which the election was made until it has filed a petition with the commissioner to be reinstated as a small employer carrier and the petition has been approved by the commissioner or the commissioner's designee. In reviewing the petition, the commissioner may ask for such information and assurances as the commissioner finds reasonable and appropriate.

§26.18. Notice to Covered Persons. Not later than the 30th day before the date on which termination of coverage is effective, a small employer carrier that cancels or refuses to renew coverage under a small employer health benefit plan under the Insurance Code, Articles 25.23 and 26. 24, shall notify the small employer of the cancellation or refusal to renew. It is the responsibility of the small employer to notify enrollees of the cancellation or refusal to renew the coverage. This notice is in addition to the notice required under the Insurance Code, Article 26.24(b), and §26.17 of this title (relating to Refusal to Renew and Application to Reenter Small Employer Market).

§26.19. Filing Requirements.

(a) Each health carrier shall file each form, including, but not limited to, each policy, contract, certificate, agreement, evidence of coverage, endorsement, amendment, enrollment form, and application, that will be used to provide a health benefit plan in the small employer market, with the department in accordance with the Insurance Code, Article 3.42 and Subchapter A of Chapter 3 of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments, and Endorsements for Life, Accident and Health Insurance and Annuities), or the Insurance Code, Article 20A.09 and §11 301(4) of this title (relating to Filing Requirements) or §11.302(6) of this title (relating to Service Area Expansion Requests), as applicable, except as provided in subsection (b) of this section.

(b) The following certification forms providing information relating to prototype policy forms, marketing in the small employer market and/or other markets, and geographic service areas, shall accompany each health benefit plan form filing submitted for use in the small employer market.

(1) A geographic service area certification (Form Number 2055 CERT GEOG) shall be submitted by each health carrier providing health benefit plans to small employers and shall define the geographic service areas within which the small employer carrier will operate as a small employer carrier.

(A) This certification form must accompany each health benefit plan form filing initially submitted for use in the small employer market.

(B) After the initial filings of health benefit plans intended for use in the small employer market have been approved, this certification form will only be due annually, no later March 1 of each calendar year; however, if the geographic service areas change at anytime, a new certification form defining the new service areas will be due no later than 30 days prior to the change.

(2) A prototype certification form (Form Number 2055 CERT PROTOTYPES/MRKT) shall accompany each policy form filing and/or certification filing. The certification form shall:

(A) state whether the carrier plans to use prototype policy forms;

(B) specify the prototype forms, if any, that the health carrier plans to use in the small employer market; and

(C) specify, describe, and explain any variance contained in the forms being filed from the provisions contained in the prototype forms. If a health carrier, other than an HMO, utilizes the prototype forms and only uses variations permitted in the prescribed and/or adopted forms, the certification with the description of the variations will suffice and policy forms will not be required to be submitted for review and approval Approval of the use of the prototype forms based on the certification and the description of the variations, will be communicated via an approval letter,

(D) define the market in which the form will be used, such as, for use only in the small employer market or in all employer markets or other markets. The certification form shall also specify whether the carrier will be marketing the form in geographic services areas previously submitted or will be marketing in new geographic service areas. If marketing in new geographic service areas, the filing shall include the certification (Form Number 2055 CERT GEOG) which defines the new geographic service areas.

(c) Each health carrier, other than an HMO, shall use a policy shell format for any group or individual health benefit plan form used to provide a health benefit plan in the small employer market To expedite the review and approval process, all group and individual health benefit plan form filings (excluding HMO filings which are covered in subsection (d) of this section) shall be submitted as follows.

(1) a group policy face page or individual policy face page, as applicable;

(2) the group certificate page or individual data page, as applicable,

(3) the toll free number and complaint notice page, as required by Subchapter E of Chapter 1 of this title (relating to Notice of Policyholder Complaint Procedure);

(4) the table of contents;

(5) insert pages for the general provisions,

(6) insert pages for the required provisions and any optional provisions, if elected and as applicable;

(7) for the standard benefit forms, which include the Preventive and Primary Care Benefit Plan, the In-Hospital Benefit Plan, and the Standard Health Benefit Plan, an insert of the required benefits section that includes the schedule of benefits, definitions, benefits provided, alternate cost containment and preferred provider provisions, if any, exclusions and limitations, continuation/conversion provisions, coordination of benefits, and riders;

(8) for small employer health benefit plans that are not one of the standard benefit forms, an insert page for the benefits section of the health benefit plan, including, but not limited to, schedule of benefits, definitions, benefits provided, alternate cost containment and preferred provider provisions, if any, exclusions and limitations, continuation/conversion provisions, coordination of benefits, and riders,

(9) insert pages for any amendments, applications, enrollment forms, or other form filings which comprise part of the contract;

(10) insert pages for any additional forms required under Chapter 3, Subchapter F of this title (relating to Group Health Insurance Mandatory Conversion Privilege),

(11) insert pages for any required Outline of Coverage for individual products,

(12) any additional form filings and documentation as outlined in Subchapter A of Chapter 3 of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments and Endorsements for Life, Accident and Health Insurance and Annuities);

(13) the certifications required under this section and any other rating information required under §26.10 of this title (relating to Establishment of Classes of Business) and §26.11 of this title (relating to Restrictions Relating to Premium Rates); and

(14) the rate schedule applicable to any individual health benefit plan, as required by §3 3(d) of this title (relating to Specific Additional Submission Requirements)

(d) In addition to subsections (a) and (b) of this section, the following provisions apply to each health carrier that is an HMO. The HMO shall submit health benefit plan forms for use in the small employer market in accordance with the following:

(1) Any HMO group or individual agreement shall address and include all required provisions of the Insurance Code, Chapter 26. Such agreement shall be in compliance with any other applicable provisions of the the Insurance Code. In addition, the agreement shall comply with the provisions of Subchapter F of Chapter 11 of this title (relating to Evidence of Coverage) where those provisions are not in conflict with the Insurance Code, Chapter 26.

(2) The filing shall include any alternate page(s) to the agreement or the schedule of benefits and any alternate schedule(s) of benefit.

(3) The filing shall include any additional riders, amendments, applications, enrollment forms, or other forms and any other required documentation outlined in Subchapter F of Chapter 11 of this title (relating to Evidence of Coverage).

(4) The filing shall include any applicable requirements of Subchapter D of Chapter 11 of this title (relating to Regulatory Requirements for an HMO Subsequent to Issuance of a Certificate of Authority), and Subchapter F of Chapter 11 of this title (relating to Evidence of Coverage)

(5) The filing shall include any rider forms that will be used with health benefit plans offered to small employers. The rider forms, if developed subsequent to approval of the agreement, shall be submitted with an explanation of the market in which the forms will be used. All rider forms shall comply with the Insurance Code, Article 20A.09, and applicable provisions of Subchapter D of Chapter 11 of this title (relating to Regulatory Requirements for an HMO Subsequent to Issuance of a Certificate of Authority) and Subchapter F of Chapter 11 of this title (relating to Evidence of Coverage)

§26.20 Reporting Requirements.

(a) Not later than November 1, 1993, each health carrier subject to the Insurance Code, Chapter 26, shall file a report with the commissioner that states the health carrier's gross premiums derived from health benefit plans delivered, issued for delivery or renewed to small employers in 1992

(b) Each health carrier, subject to the Insurance Code, Chapter 26, shall file a report with the commissioner that states the health carrier's gross premiums derived from health benefit plans delivered, issued for delivery, or renewed to small employers:

(1) for the period of January 1994-March 1994, not later than April 31, 1994,

(2) for the period of April 1994-June 1994, not later than July 31, 1994;

(3) for the period of July 1994-September 1994, not later than October 31, 1994; and

(4) for the period of October 1994-December 1994, not later than January 1, 1995.

(c) Not later than November 1, 1994, each health carrier subject to the Insurance Code, Chapter 26, shall file with the commissioner an update to the report required by subsection (a) of this section.

(d) For purposes of the reports required under subsections (a), (b), and (c) of this section, gross premiums shall be the total amount of monies collected by the health carrier for health benefit plans during the applicable calendar year or the applicable calendar quarter. Gross premiums shall include premiums collected for individual and group health benefit plans issued to small employers or their employees. Gross premiums shall also include premiums collected under certificates issued or delivered to employees (in this state) of small employers, regardless of where the policy is issued or delivered. Reports under subsections (a)-(c) of this section shall be filed on Form Number 2055 CERT GROSS PREM.

(e) Small employer health carriers offering a small employer health benefit plan shall file annually, not later than March 1 of each year, an actuarial certification (Cert 2055 Actuarial) stating that the underwriting and rating methods of the small employer carrier:

(1) comply with accepted actuarial practices;

(2) are uniformly applied to each small employer health benefit plan covering a small employer; and

(3) comply with the provisions of the Insurance Code, Chapter 26 and this chapter.

(f) Not later than March 1, of each calendar year, each health carrier shall file a certification (Cert 2055 Ann List-Other/SEHBP) with the commissioner, stating whether the health carrier is offering any health benefit plan to small employers that is subject to the Insurance Code, Article 26.06(a). The certification shall:

(1) list each other health insurance coverage (including the form number, approval date, and a very brief description of the type of coverage) that the health carrier is offering, delivering, issuing for delivery, or renewing to or through small employers in this state; and is not subject to this chapter because it is listed as excluded from the definition of a health benefit plan under the Insurance Code, Article 26.02, and §26.4 of this title (relating to Definitions);

(2) include a statement that the health carrier is not offering or marketing to

small employers as a health benefit plan, the coverage listed under the Insurance Code, Article 26.07(b) and paragraph (1) of this subsection, and the health carrier is complying with the provisions of the Insurance Code, Chapter 26, and this chapter to the extent it is applicable to the health carrier;

(3) list each health benefit plan along with riders (including the form number and approval date) previously filed with the department (or filed through the certification process) which the health carrier is no longer marketing to small employers in the state. If the health carrier no longer wishes to offer the plan, a formal withdrawal of the plan shall be filed and can be accomplished by marking the appropriate blank on the certification (Form Number 2055 CERT ANN LIST-OTHER/SEHBP); and

(4) list each health benefit plan and rider (including the form number and approval date) previously filed with the department which the health carrier plans to continue marketing to small employers in the state.

(g) Not later than March 1 of each calendar year, a small employer carrier shall file with the commissioner Form Number 2055 CERT DATA, the following information related to health benefit plans issued by the small employer carrier to small employers in this state:

(1) the number of small employers that were issued and the number of lives that were covered under health benefit plans 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 that were covered under the preventive and primary care benefit plan, the in-hospital benefit plan, and the standard health benefit plan in the previous calendar year (separated 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 that were covered under a prescription drug rider with the preventive and primary care benefit plan; a preventive and primary care benefit rider with the in-hospital benefit 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 those 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 employers in the previous calendar year;

(6) the number of small employer health benefit plans that were terminated or non renewed (for reasons other 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 uninsured for at least the two months prior to issue.

§26.21. Cost Containment.

(a) Small employer carriers may utilize cost containment and managed care features in a small employer health benefit plan, including.

(1) utilization review of health care services, including review of the medical necessity of hospital and physician services;

(2) case management, including discharge planning and review of stays in hospitals or other health care facilities,

(3) selective contracting with hospitals, physicians, and other health care providers in accordance with the requirements of subsection (b) of this section;

(4) benefit differentials applicable to health care providers that participate or do not participate in restricted network arrangements in accordance with the requirements of subsection (b) of this section;

(5) precertification or preauthorization for certain covered services; and

(6) coordination of benefits.

(b) Health carriers, other than HMOs, utilizing restricted network arrangements shall establish reasonable benefit differentials between participating and nonparticipating providers. A reasonable benefit differential will be considered to exist if the plan complies with the provisions of Subchapter X of Chapter 3 of this title (relating to Preferred Provider Plans) For purposes of complying with the cost containment permitted by the Insurance Code, Article 26.08, and this section, health carriers may limit participation in any participating provider network to a selected number of providers of each particular type recognized under the Insurance Code, Articles 20.11, 21 52, and 21.53, but must comply with those articles. This selective contracting for the purposes of complying with the Insurance Code, Article 26.08, and this section shall not be considered a violation of Subchapter X of Chapter 3 of this title (relating to Preferred Provider Plans). Health carriers may not restrict the participating provider network for pharmacists covered by the Insurance Code, Article 21.52B, and must comply with that article. HMOs are not subject to Subchapter X of Chapter 3 of this title (relating to Preferred Provider Plans) or the Insurance Code, Article 21.52B.

§26.22. Private Purchasing Cooperatives.

(a) Two or more small employers may form a cooperative for the purchase of small employer health benefit plans. A cooperative must be organized as a nonprofit corporation and has the rights and duties provided by the Texas Non-Profit Corporation Act, Texas Civil Statutes, Article 1396-1.01, et seq.

(b) The board of directors shall file annually with the commissioner a statement of all amounts collected and expenses incurred for each of the preceding years. The annual filing shall be made on form (2055 CERT COOP) and shall be mailed to the Life/Health Group, Mail Code 106-1D, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

§26.23. Powers and Duties of Texas Health Benefits Purchasing Cooperative and Private Purchasing Cooperatives.

(a) A private purchasing cooperative described in §26.23 of this title (relating to Private Purchasing Cooperatives) and the Texas Health Benefits Purchasing Cooperative described in the Insurance Code, Article 26.13:

(1) shall arrange for small employer health benefit plan coverage for small employer groups who participate in the cooperative by contracting with small employer carriers who meet the criteria established in the Insurance Code, Article 26.15(b), and subsection (b) of this section;

(2) shall collect premiums to cover the cost of:

(A) small employer health benefit plan coverage purchased through the cooperative, and

(B) the cooperative's administrative expenses;

(3) may contract with agents to market coverage issued through the cooperative;

(4) shall establish administrative and accounting procedures for the operation of the cooperative;

(5) shall establish procedures under which an applicant for or participant in coverage issued through the cooperative may have a grievance reviewed by an impartial person;

(6) may contract with a small employer carrier or third-party administrator to provide administrative services to the cooperative;

(7) shall contract with small employer carriers for the provision of services to small employers covered through the cooperative;

(8) shall develop and implement a plan to maintain public awareness of the cooperative and publicize the eligibility requirements for, and the procedures for enrollment in coverage through, the cooperative; and

(9) may negotiate the premiums paid by its members.

(b) A cooperative may contract only with small employer carriers who desire to offer coverage through the cooperative and who demonstrate:

(1) that the carrier is a health carrier or health maintenance organization licensed and in good standing with the department;

(2) the capacity to administer the health benefit plans;

(3) the ability to monitor and evaluate the quality and cost effectiveness of care and applicable procedures;

(4) the ability to conduct utilization management and applicable procedures and policies;

(5) the ability to assure enrollees adequate access to health care providers, including adequate numbers and types of providers;

(6) a satisfactory grievance procedure and the ability to respond to enrollees' calls, questions, and complaints; and

(7) financial capacity, either through financial solvency standards as applied by the commissioner or through appropriate reinsurance or other risk-sharing mechanisms.

(c) A cooperative may not self-insure or self-fund any health benefit plan or portion of a plan.

(d) A cooperative shall comply with federal laws applicable to cooperatives and health benefit plans issued through cooperatives.

§26.24. Procedure for Obtaining the Approval of Commissioner and Filing with the Commissioner.

(a) Whenever the approval of the commissioner is required by this chapter, the initial approval shall be granted or denied by the Deputy Commissioner for the Life/Health Group. The initial decision is expressly delegated by this section to the Deputy Commissioner for the Life/Health Group. The applicant for the approval may appeal the initial decision to the commissioner.

(b) Whenever a filing of a policy, contract or form is required by §26.19 of this title (relating to Filing Requirements), any approval, withdrawal or disapproval of the filing shall initially be made by the Deputy Commissioner for the Life/Health Group. Notice of any adverse action shall be given to the applicant not later than the fifth day before the action is proposed to be taken. The applicant may appeal an adverse decision to the commissioner.

(c) Whenever a report is required to be filed by this chapter, that filing shall be made to the Deputy Commissioner, Life/Health Group, Mail Code 106-1A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104.

§26.25. Unfair Competition and Unfair Practices Under the Insurance Code, Article 21.21. A misrepresentation about the effects of the Insurance Code, Chapter 26, and/or this chapter in marketing small employer health plans or in the marketing, renewing or cancelling of other health insurance products will be considered a violation of the Insurance Code, Articles 21.20 and 21.21.

§26.26. Administrative Violations and Penalties. If, after notice and hearing, the commissioner determines that a health carrier or a small employer carrier has violated or is violating any provision of the Insurance Code, Chapter 26, or this chapter, the commissioner may impose sanctions under the Insurance Code, Article 1.10, and/or issue a cease and desist order under the Insurance Code, Article 1.10A.

§26.27. Appendix. The forms adopted and incorporated in §26.2 of this title (relating to Forms adopted and Incorporated by Reference) are included in the Appendix to these sections. The following index refers to the form number, its description, and the figure number in the appendix.

FORM NUMBER	FIGURE NO.	DESCRIPTION
2055 SE.PP	1	Group Policy Face Page - Preventive and Primary Care Benefit Plan (single employer)
2055 SE.IH	2	Group Policy Face Page - In-Hospital Benefit Plan (single employer)
2055 SE.STD	3	Group Policy Face Page - Standard Health Benefit Plan (single employer)
2055 MET.PP	4	Group Policy Face Page - Preventive and Primary Care Benefit Plan (MET)

2055 MET.IH	5	Group Policy Face Page - In-Hospital Benefit Plan (MET)
2055 MET.STD	6	Group Policy Face Page - Standard Health Benefit Plan (MET)
2055 ASSN.PP	7	Group Policy Face Page - Preventive and Primary Care Benefit Plan (Association)
2055 ASSN.IH	8	Group Policy Face Page - In-Hospital Benefit Plan (Association)
2055 ASSN.STD	9	Group Policy Face Page - Standard Health Benefit Plan (Association)
2055 ISE.PP	10	Individual Policy Face Page - Preventive and Primary Care Benefit Plan
2055 ISE.IH	11	Individual Policy Face Page - In-Hospital Benefit Plan
2055 ISE.STD	12	Individual Policy Face Page - Standard Health Benefit Plan
TOLLFREE	13	Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures
2055 CERT.PP	14	Group Certificate Face Page - Preventive and Primary Care Benefit Plan
2055 CERT.IH	15	Group Certificate Face Page - In-Hospital Benefit Plan
2055 CERT.STD	16	Group Certificate Face Page - Standard Health Benefit Plan
2055 DP	17	Individual Data Page
2055 TCG	18	Group Table of Contents
2055 TCI	19	Individual Table of Contents
2055 GGP	20	Group General Provisions
2055 IGP	21	Individual General Provision

2055 GRP	22	Group Provisions
2055 IRP	23	Individual Provisions
2055 SCH.PP	24	Schedule of Benefits (Non-PPO) Preventive and Primary Care Benefit Plan
2055 SCHPO.PP	25	Schedule of Benefits (PPO) Preventive and Primary Care Benefit Plan
2055 DEF.PP	26	Policy Definitions - Preventive and Primary Care Benefit Plan
2055 BEN.PP	27	Benefits Provided - Preventive and Primary Care Benefit Plan
2055 EXC.PP	28	Exclusions and Limitations Preventive and Primary Care Benefit Plan
2055 PDR	29	Prescription Drug Benefit Rider Preventive and Primary Care Benefit Plan
2055 SCH.IH	30	Schedule of Benefits (Non-PPO) In-Hospital Benefit Plan
2055 SCHPO.IH	31	Schedule of Benefits (PPO) In-Hospital Benefit Plan
2055 SCH.PPR	32	Schedule of Benefits for the Preventive and Primary Care Benefit Rider (Non-PPO) In-Hospital Benefit Plan
2055 SCHPO.PPR	33	Schedule of Benefits for the Preventive and Primary Care Benefit Rider (PPO) In-Hospital Benefit Plan
2055 DEF.IH	34	Policy Definitions In-Hospital Benefit Plan

2055 BEN.IH	35	Benefits Provided In-Hospital Benefit Plan
2055 EXC.IH	36	Exclusions and Limitations In-Hospital Benefit Plan
2055 ACCR	37	Supplementary Accidental Injury Benefit Rider In-Hospital Benefit Plan
2055 PPR	38	Preventive and Primary Care Benefit Rider In-Hospital Benefit Plan
2055 SCH.STD	39	Schedule of Benefits (Non-PPO) Standard Health Benefit Plan
2055 SCHPO.STD	40	Schedule of Benefits (PPO) Standard Health Benefit Plan
2055 DEF.STD	41	Policy Definitions Standard Health Benefit Plan
2055 BEN.STD	42	Benefits Provided Standard Health Benefit Plan
2055 EXC.STD	43	Exclusions and Limitations Standard Health Benefit Plan
2055 ACD	44	Alternate Benefits for Chemical Dependency Standard Health Benefit Plan
2055 ACC	45	Alternate Cost Containment Provisions (all plans)
2055 COP	46	Continuations/Conversion Provisions (group plans)
2055 COB	47	Coordination of Benefits (all plans)
2055 PPO	48	Preferred Provider Provisions (all plans)

2055 CDW	49	Chemical Dependency Benefit Waiver Rider Preventive and Primary Care Benefit Plan/Standard Health Benefit Plan
2055 OC.PP	50	Outline of Coverage Individual Preventive and Primary Care Benefit Plan (Non-PPO)
2055 OC.PDR	51	Outline of Coverage Insert - Prescription Drug Rider Preventive and Primary Care Benefit Plan (Non-PPO)
2055 OCPO.PP	52	Outline of Coverage Individual Preventive and Primary Care Benefit Plan (PPO)
2055 OC.IH	53	Outline of Coverage Individual In-Hospital Benefit Plan (Non-PPO)
2055 OC.ACCR	54	Outline of Coverage insert Supplementary Accidental Injury Benefit Rider In-Hospital Benefit Plan (Non-PPO and PPO)
2055 OC.PPR	55	Outline of Coverage insert Preventive and Primary Care Benefit Rider In-Hospital Benefit Plan (Non-PPO)
2055 OCPO.IH	56	Outline of Coverage Individual In-Hospital Benefit Plan (PPO)
2055 OCPO.PPR	57	Outline of Coverage Insert Preventive and Primary Care Benefit Rider In-Hospital Benefit Plan (PPO)
2055 OC.STD	58	Outline of Coverage Individual Standard Health Benefit Plan (Non-PPO)

2055 OCPO.STD	59	Outline of Coverage Individual Standard Health Benefit Plan (PPO)
2055 HMO-PP	60	Small Group Primary and Preventive Benefit Plan. Includes required benefit language for HMOs.
2055 HMO-STAN	61	Small Group Standard Health Benefit Plan. Includes required benefit language for HMOs.
2055 HMO-CONT	62	Texas Small Employer Group Health Benefit Plan Contract and Certificate of Coverage. Includes optional standard provision language for HMOs.
2055 CERT SEHC STATUS	63	Certification form status of health carriers as small employer carriers
2055 CERT PROTOTYPES/MRKT	64	Certification form specifying prototypes forms, if any, health carrier plans to use in small employer market and whether for use only in small employer markets or all employer markets or otherwise
2055 CERT GEOG	65	Certification form defining (on an annual basis or upon change) geographic service areas within which small employers will operate as a small employer carrier
2055 CERT ACTUARIAL	66	Actuarial Certification form providing required actuarial certification on an annual basis
2055 CERT COOP	67	Annual filing for private purchasing coops
2055 CERT GROSS PREM	68	Report of gross premiums

2055 CERT ANN LIST-OTHER/SEHBP	69	Certification form listing, on an annual basis, small employer health benefit plans and other plans (sold to small employers) not subject to Insurance Code, Chapter 26
2055 CERT DATA	70	Form listing information on small employer health plans insured by small employer carriers

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued in Austin, Texas, on October 22, 1993.

TRD-9330862 Linda K. von Quintus-Dorn
Chief Clerk
Texas Department of Insurance

Earliest possible date of adoption: November 29, 1993

For further information, please call: (512) 463-6327

♦ ♦ ♦

(Editor's Note: The following pages are a continuation of Texas Department of Insurace proposed rule §26.27.)

REGULATION TO IMPLEMENT THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT (HB 2055)

OPTIONAL PROTOTYPE POLICY FORMS

Policy Face Pages
Toll Free Telephone No. and Information Notice
Certificate Face Pages
Individual Data Page
Group/Individual Table of Contents
Group/Individual General Provisions
Individual/Group Provisions

Figure 1

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [ABC SMALL EMPLOYER]
(Employer) [ADDRESS]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [1/1/94]

This Policy is issued in consideration of the Policyholder's application and payment of the first premium. The provisions of this Policy and the attached applications, the Certificate of Insurance and any attached riders constitute the entire contract. We agree to pay benefits as provided within for the Insured Persons of the Policyholder.

This Policy is effective from 12:01 A.M., at the Policyholder's address, on the Effective Date shown above.

[If for any reason, the Employer is not satisfied with this Policy, it may be returned to Us or our authorized representative within 10 days after it is received. We will refund any premium paid to Us and the Policy will be void provided that no claims for benefits have been submitted.]

This Policy is issued in the State of Texas and is governed in accordance with the laws of this State.

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.

Executed by [ABC Small Employer Carrier] as of (Date).

Secretary _____ President _____

Group Small Employer Preventive and Primary Care Benefit Plan

2055 SE.PP

Figure 2

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [ABC SMALL EMPLOYER]
(Employer) [ADDRESS]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [XXXX]

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Executed by [ABC Small Employer Carrier] as of (Date).

_____ _____
Secretary President

Group Small Employer In-Hospital Benefit Plan

2055 SE.IH

Figure 3

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [ABC SMALL EMPLOYER]
(Employer) [ADDRESS]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [1/1/94]

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Executed by [ABC Small Employer Carrier] as of (Date).

Secretary President

Group Small Employer Standard Health Benefit Plan

2055 SE.STD

Figure 4

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [MULTIPLE EMPLOYER TRUST]
[INDUSTRY]
[ADDRESS]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [1/1/94]

This Policy is issued in consideration of the Policyholder's application and payment of the first premium. The provisions of this Policy and the attached applications, the Certificate of Insurance and any attached riders constitute the entire contract. We agree to pay benefits as provided within for the Insured Persons of the Policyholder.

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Executed by [ABC Small Employer Carrier] as of (Date).

Secretary _____ President _____

Group Small Employer Preventive and Primary Care Benefit Plan

2055 MET.PP

Figure 5

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [MULTIPLE EMPLOYER TRUST]
[INDUSTRY]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [1/1/94]

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Executed by [ABC Small Employer Carrier] as of (Date).

_____ _____
Secretary President

Group Small Employer In-Hospital Benefit Plan

2055 MET.IH

Figure 6

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [MULTIPLE EMPLOYER TRUST]
[INDUSTRY]
[ADDRESS]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [1/1/94]

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Executed by [ABC Small Employer Carrier] as of (Date).

Secretary _____ President _____

Group Small Employer Standard Health Benefit Plan

2055 MET.STD

Figure 7

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [ASSOCIATION]
[ADDRESS]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [1/1/94]

This Policy is issued in consideration of the Policyholder's application and payment of the first premium. The provisions of this Policy and the attached applications, the Certificate of Insurance and any attached riders constitute the entire contract. We agree to pay benefits as provided within for the Insured Persons of the Policyholder.

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Executed by [ABC Small Employer Carrier] as of (Date).

Secretary _____ President _____

Group Small Employer Preventive and Primary Care Benefit Plan

2055 ASSN.PP

Figure 8

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [ASSOCIATION]
[ADDRESS]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [XXXX]

This Policy is issued in consideration of the Policyholder's application and payment of the first premium. The provisions of this Policy and the attached applications, the Certificate of Insurance and any attached riders constitute the entire contract. We agree to pay benefits as provided within for the Insured Persons of the Policyholder.

This Policy is effective from 12:01 A.M., at the Policyholder's address, on the Effective Date shown above.

[If for any reason, the Policyholder is not satisfied with this Policy, it may be returned to Us or our authorized representative within 10 days after it is received. We will refund any premium paid to Us and the Policy will be void provided that no claims for benefits have been submitted.]

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.

Executed by [ABC Small Employer Carrier] as of (Date).

_____ _____
Secretary President

Group Small Employer In-Hospital Benefit Plan

2055 ASSN.IH

Figure 9

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

POLICYHOLDER: [ASSOCIATION]
(Employer) [ADDRESS]

POLICY NUMBER: [XXXX]
POLICY EFFECTIVE DATE: [1/1/94]

This Policy is issued in consideration of the Policyholder's application and payment of the first premium. The provisions of this Policy and the attached applications, the Certificate of Insurance and any attached riders constitute the entire contract. We agree to pay benefits as provided within for the Insured Persons of the Policyholder.

This Policy is effective from 12:01 A.M., at the Policyholder's address, on the Effective Date shown above.

[If for any reason, the Policyholder is not satisfied with this Policy, it may be returned to Us or our authorized representative within 10 days after it is received. We will refund any premium paid to Us and the Policy will be void provided that no claims for benefits have been submitted.]

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.

Executed by [ABC Small Employer Carrier] as of (Date).

_____ _____
Secretary President

Group Small Employer Standard Health Benefit Plan

2055 ASSN.STD

Figure 10

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

GUARANTEED RENEWABLE FOR LIFE
WE RESERVE THE RIGHT TO CHANGE PREMIUM RATES

POLICYHOLDER (hereinafter called you): [Employee's Name and Address]

POLICY NUMBER: [XXXX] POLICY EFFECTIVE DATE: [XXXXXX]

This Policy is issued in consideration of your application and payment of the first premium. The provisions of this Policy and the attached application, and any attached papers constitute the entire contract. We agree to pay benefits as provided within for you or any Insured Person.

EFFECTIVE DATE: This Policy is effective from 12:01 A.M., at the Policyholder's address, on the Effective Date shown above.

RIGHT TO EXAMINE POLICY: If for any reason, you are not satisfied with this Policy, it may be returned to Us or Our authorized representative within 10 days after it is received. We will refund any premium paid to Us and the Policy will be void.

This Policy is issued in the State of Texas and is governed in accordance with the laws of this State.

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.

Executed by [ABC Small Employer Carrier] as of (Date).

Secretary President

Individual Small Employer Preventive and Primary Care Benefit Plan

2055 ISE.PP

Figure 11

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

GUARANTEED RENEWABLE FOR LIFE
OR
PAYMENT OF THE LIFETIME MAXIMUM
WE RESERVE THE RIGHT TO CHANGE PREMIUM RATES

POLICYHOLDER (hereinafter called you): [Employee's name and address]

POLICY NUMBER: [XXXX] POLICY EFFECTIVE DATE: [1/1/94]

This Policy is issued in consideration of your application and payment of the first premium. The provisions of this Policy and the attached application, and any attached papers constitute the entire contract. We agree to pay benefits as provided within for you or any Insured Person.

EFFECTIVE DATE: This Policy is effective from 12:01 A.M., at your address, on the Effective Date shown above.

RIGHT TO EXAMINE POLICY: If for any reason, you are not satisfied with this Policy, it may be returned to Us or Our authorized representative within 10 days after it is received. We will refund any premium paid to Us and the Policy will be void.

This Policy is issued in the State of Texas and is governed in accordance with the laws of this State.

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.

Executed by [ABC Small Employer Carrier] as of (Date).

_____ _____

Secretary President

Individual Small Employer In-Hospital Benefit Plan

2055 ISE.IH

Figure 12

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]
(herein called We, Our, or Us)

GUARANTEED RENEWABLE FOR LIFE
OR
UNTIL LIFETIME MAXIMUM HAS BEEN PAID
WE RESERVE THE RIGHT TO CHANGE PREMIUM RATES

POLICYHOLDER (hereinafter called you): (Employee name and address)

POLICY NUMBER: [XXXX] POLICY EFFECTIVE DATE: [XXXX]

This Policy is issued in consideration of your application and payment of the first premium. The provisions of this Policy and the attached application, and any attached papers constitute the entire contract. We agree to pay benefits as provided within for you or any Insured Person.

EFFECTIVE DATE: This Policy is effective from 12:01 A.M., at your address, on the Effective Date shown above.

RIGHT TO EXAMINE POLICY: If for any reason, you are not satisfied with this Policy, it may be returned to Us or Our authorized representative within 10 days after it is received. We will refund any premium paid to Us and the Policy will be void.

This Policy is issued in the State of Texas and is governed in accordance with the laws of this State.

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.

Executed by [ABC Small Employer Carrier] as of (Date).

_____ _____
Secretary President

Individual Small Employer Standard Health Benefit Plan

2055 ISE.STD

Figure 13

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 complaint 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 your premium or about a claim you should contact the (agent) (company) (agent or the company) first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

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

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 de 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 reclamo, debe comunicarse con el (agente) (la compania) (agente o la compania) primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

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

Figure 14

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]

CERTIFICATE OF INSURANCE

[EMPLOYEE: [XXXXX]
ID NUMBER: [XXX]
CERTIFICATE EFFECTIVE DATE: [XXXXXX]

POLICYHOLDER: [XXXXXXXXXXXXX]
POLICY NUMBER: [XXX]
POLICY EFFECTIVE DATE: [XXXXXX]

We certify that coverage is provided for each Insured Person in accordance with the terms of the Group Insurance Policy.

This page, all attached provisions, and any riders will constitute the entire Certificate of Insurance.

[This Certificate of Insurance replaces any previous certificate issued to you for the coverage described in the Certificate. All benefits are subject in every way to the entire Group Insurance Policy which includes this Certificate of Insurance.]

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER OR NOT YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.

Small Employer Preventive and Primary Care Benefit Plan

2055 CERT.PP

Figure 15

(ABC SMALL EMPLOYER CARRIER)
(ADDRESS)

CERTIFICATE OF INSURANCE

[EMPLOYEE: [XXXXXXX]
ID NUMBER: [XXXXXX]
CERTIFICATE EFFECTIVE DATE: [XXXXXX]

POLICYHOLDER: [XXXXXXXXXX]
POLICY NUMBER: [XXX]
POLICY EFFECTIVE DATE: [XXXXXX]

We certify that coverage is provided for each Insured Person in accordance with the terms of the Group Insurance Policy.

This page, all attached provisions, and any riders will constitute the entire Certificate of Insurance.

[This Certificate of Insurance replaces any previous Certificate issued to you for the coverage described in the Certificate. All benefits are subject in every way to the entire Group Insurance Policy which includes this Certificate of Insurance.]

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER OR NOT YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Small Employer In-Hospital Benefit Plan

2055 CERT.IH

Figure 16

(ABC SMALL EMPLOYER CARRIER)
(ADDRESS)

CERTIFICATE OF INSURANCE

[EMPLOYEE: [XXXXXXXX]
ID NUMBER: [XXX]
CERTIFICATE EFFECTIVE DATE: [XXXXXX]

POLICYHOLDER: [XXXXXXXXXXXX]
POLICY NUMBER: [XXX]
POLICY EFFECTIVE DATE: [XXXXXX]

We certify that coverage is provided for each Insured Person in accordance with the terms of the Group Insurance Policy.

This page, all attached provisions, and any riders will constitute the entire Certificate of Insurance.

[This Certificate of Insurance replaces any previous Certificate issued to you for the coverage described in the Certificate. All benefits are subject in every way to the entire Group Insurance Policy which includes this Certificate of Insurance.]

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER OR NOT YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKER'S COMPENSATION SYSTEM.

Small Employer Standard Health Benefit Plan

2055 CERT.STD

Figure 17

[ABC SMALL EMPLOYER CARRIER]
[ADDRESS]

DATA PAGE

PREMIUM: [XXXX]

PREMIUM MODE: [MONTHLY]

DEPENDENT COVERAGE: [YES]
[DEPENDENT'S NAME]

[POLICY FEE: _____]

2055 DP

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Figure 20

GENERAL PROVISIONS

ELIGIBILITY FOR COVERAGE

Employee Coverage:

You are an Eligible Employee if you:

1. work on a full time basis; and
2. usually work at least 30 hours a week

Eligible Employee 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 the Employer. [Eligible Employee also includes an Employee of an Employer member of an association.] The term does not include:

1. an Employee who works on a part-time, temporary or substitute basis; or
2. an Employee who is covered under:

    a. another Health Benefit Plan; or
    b. an employee welfare benefit plan that provides health benefits and that is established in accordance with Employee Retirement Income Security Act of 1974.

Dependent Coverage:

Eligible Dependents are:

1. your spouse;
2. a Child under the age of 19 years;
3. a Child who is a full-time student under the age of 23 years and who is financially dependent on the parent;
4. a Child of any age who is medically certified as disabled and dependent on the parent; and
5. a grandchild who is dependent on the Employee for federal income tax purposes.

The marital status of the Employee and the other parent shall not be used in determining the Dependents or Beneficiary.

2055 GGP

If both husband and wife are Employees of the Employer, such Employees shall not be eligible for coverage as a Dependent under the Policy. Each must be covered as an Employee.

If both husband and wife are Employees, only one is eligible for Dependent coverage.

EFFECTIVE DATES

Eligible Employees:

In order for an Eligible Employee's coverage to take effect, the Eligible Employee must submit written enrollment for coverage for himself and any Dependents. The Effective Date of coverage under the Policy is the date shown in the Certificate of Insurance issued to the Insured Person.

Any person covered by a previous group health plan of the Employer on the day prior to the Policy Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Policy Effective Date.

Coverage under the Policy shall become effective on the Policy Effective Date for all existing Eligible Employees and Dependents upon completion of an application and election of coverage. This includes any Eligible Employee or Dependent who is confined in a Hospital or other institution. If the Policy is replacing a discontinued group health plan, coverage for an Eligible Employee or Dependent may be delayed only until the expiration of any applicable extension of benefits provided by the previous group health plan.

Initial Enrollment for New Eligible Employees:

If We receive your application or enrollment form within 31 days of your date of employment, your coverage will become effective on the first day of the month following the date that written application for coverage for you and any Dependents is received [and any Waiting Period has been satisfied. The **Waiting Period** is the length of time that you must be continuously employed before your coverage may become effective under the Policy. The Waiting Period under the Policy is [90] days from the first date of employment.]

If you do not enroll within 31 days of your employment date, coverage will become effective in accordance with the provisions for Late Enrollees.

Dependents:

If you have eligible Dependents on the date your coverage begins, your Dependents' coverage will begin on your Certificate Effective Date if:

1. you enroll your Dependent for coverage on or before your Effective Date; and
2. you pay the appropriate premium.

If you have Dependents who are not enrolled on the date your coverage begins and you subsequently apply for Dependent coverage, coverage for your Dependent(s) will become effective in accordance with the provision for Late Enrollees.

Newly Acquired Dependents:

If you acquire new eligible Dependents after the date your coverage begins, coverage for your Dependent will become effective in accordance with the following provisions:

Newborn Children

Coverage will be automatic for the first 31 days following the birth of your newborn Child. To continue coverage beyond 31 days, you must notify Us and pay the required premium within that 30 day period. If you notify Us after that 30 day period, your newborn Child will become effective in accordance with the provisions for Late Enrollees. [If you decide not to continue coverage for your Dependent Child beyond the 31 day period, premium will be charged for the 31 days coverage was in force.]

Court Ordered Coverage for a Dependent

If a court has ordered you to provide coverage for a spouse or minor Child, coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage beyond 31 days, you must notify Us and pay the required premium within that 31 day period. If you notify Us after that 31 day period, your Dependent will become effective in accordance with the provisions for Late Enrollees.

Other Dependents

Written enrollment must be received within 31 days of the date that a spouse or Child first qualifies as an eligible Dependent. Coverage will become effective on the first day of the month following the date that application for coverage is received. If application is not made within the initial 31 days, then your

Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

If you have coverage for your spouse and existing children or coverage for existing children only, coverage for any additional children will become effective as of the date they become your Dependent provided that enrollment for coverage is made within 31 days of eligibility.

If you ask that your Dependent be insured again after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

In no event will your Dependent's coverage become effective for coverage prior to your Certificate Effective Date.

Late Enrollees:

Late Enrollee means any Eligible Employee or Dependent who requests enrollment in the 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 Effective Dates provision or otherwise in effect at the time of your employment date.

[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.]

Exceptions to Late Enrollee Provisions:

The Employee or Dependent will not be considered a Late Enrollee, if the Employee or Dependent did not enroll for coverage within the Initial Enrollment Period and:

1. was covered under another Employer Health Benefit Plan during the Initial Enrollment Period; and

2. declined coverage under this Policy in writing on the basis of the coverage under another Employer Health Benefit Plan; and
3. coverage under the other Health Benefit Plan is terminating due to termination of the plan, termination of employment, death of a spouse, or divorce.

The Employee or Dependent must enroll within 31 days after the date that coverage ends under another Employer Health Benefit Plan. If enrollment is not requested within this 31 days, coverage for the Employee or Dependent will become effective in accordance with the provisions for Late Enrollees.

[PREEXISTING CONDITIONS

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be paid for a period of 12 months from the Insured Person's Effective Date of coverage.

The Preexisting Condition limitation shall not apply to an Insured Person who was continuously covered for a minimum of 12 months by a Health Benefit Plan that was in effect up to a date not more than 60 days before the Effective Date of coverage under the Policy.

Credit shall be given for the time the Insured Person was covered under a previous Health Benefit Plan if the previous Health Benefit Plan was in effect at any time during the 12 months before the Effective Date of coverage under the Policy.]

TERMINATION OF INSURANCE

Eligible Employees:

Your coverage will end on the earlier of:

1. the first day of the month after the date you no longer meet the definition of an Eligible Employee including termination of employment. [However, when you are on approved leave of absence, coverage may be continued for up to [1 year], if premiums continue to be paid to Us by you or on your behalf];
2. the end of the last period for which premium payment has been made to Us, [subject to the Grace Period provision of the Policy];

3. the date the Policy terminates;
4. the date any Lifetime Maximum Benefits have been exhausted;
5. the date of fraud or misrepresentation of a material fact by you, except as indicated in the Time Limit on Certain Defenses provision.

[6. the date the Employer terminates participation in the trust.]

[6. the date the Employer terminates membership in the association.]

Dependents:

Your Dependent's coverage will end on the earlier of:

1. the date your Dependent no longer meets the definition of Dependent, as defined in the Policy;
2. the end of the period for which premium payment has been made to Us, [subject to the Grace Period provision of the Policy];
3. the date the Policy terminates;
4. the date your coverage terminates (unless due to exhaustion of any Lifetime Maximum Benefits available for you);
5. the date any Lifetime Maximum Benefits have been exhausted;
6. the date of fraud or misrepresentation of a material fact by the Dependent, except as indicated in the Time Limit on Certain Defenses provision.

[7. the date the Employer terminates participation in the Trust.]

[7. the date the Employer terminates membership in the Association.]

Policyholder and Company:

The coverage of all Insured Persons shall terminate if the Policy is terminated.

[The policy may be terminated by the Employer on any premium due date. The Employer must request cancellation in writing at least 30 days in advance.]

[The policy may be terminated by the Association on any premium due date. The Association must request cancellation in writing at least 30 days in advance.]

[The Employer may terminate participation under the Policy on any premium due date. The Employer must request cancellation in writing at least 30 days in advance.]

[The Employer (Member) may terminate participation under the Policy on any premium due date. The Employer (Member) must request cancellation at least 30 days in advance.]

The Policy may be terminated by Us:

1. for non-payment of premiums [, except for the Grace Period provision]. [Coverage will end at the end of the last period for which premium payment has been made to Us];

2. on any premium due date for any of the following reasons. We must give the Employer written notice of cancellation at least 30 days in advance if termination is due to:

   a. fraud or misrepresentation of a material fact by the [Policyholder or] Employer, except as indicated the Time Limit on Certain Defenses provision;
   b. failure to maintain the required minimum premium contribution;
   c. failure to provide required information or documentation related to the Employer Health Benefit Plan upon request.
   [d. failure to maintain the required minimum participation requirements];
   [e. failure to maintain status as an Employer as defined in the Policy Definition provision.]

3. on any premium due date if We are also canceling all Small Employer Health Benefit Plans in the state or in a geographic service area. We must give the Employer written notice of cancellation:

   a. at least 180 days in advance and
   b. again at least 30 days in advance.

Figure 21

GENERAL PROVISIONS

GUARANTEED RENEWABLE: We will renew this Policy for any Policyholder's life or payment of maximum benefits, if any. We will renew this Policy each time We receive the correct premium before the end of the Grace Period. If you leave your Employer, you will be required to pay the entire premium in order to keep the Policy in force. Additionally, if your Employer elects to no longer pay premiums, you may keep this Policy in force by paying the required premium. While this Policy is in force, We cannot change the benefits without your consent.

RATES: We may change the premium rates for this Policy from time to time. Such change shall be made for all policies of this form in a particular class as determined by Us. No premium change may be made on an individual basis.

ELIGIBILITY FOR COVERAGE

Employee Coverage: You are an Eligible Employee if you:

1. work on a full time basis; and
2. usually work at least 30 hours a week.

Eligible Employee 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 the Employer. The term does not include:

1. an Employee who works on a part-time, temporary or substitute basis; or
2. an Employee who is covered under:
   a. another Health Benefit Plan; or
   b. an employee welfare benefit plan that provides health benefits and that is established in accordance with Employee Retirement Income Security Act of 1974.

2055 IGP

Dependent Coverage: Eligible Dependents are:

1. your spouse;
2. a Child under the age of 19 years;
3. a Child who is a full-time student under the age of 23 years and who is financially dependent on the parent;
4. a Child of any age who is medically certified as disabled and dependent on the parent; and
5. a grandchild who is dependent on the Employee for federal income tax purposes.

The marital status of the Employee and the other parent shall not be used in determining the Dependents or Beneficiary.

If both husband and wife are Employees of the Employer, such Employees shall not be eligible for coverage as a Dependent under the Policy. Each must be covered as an Employee.

If both husband and wife are Employees, only one is eligible to include children under this Policy.

EFFECTIVE DATES

Eligible Employees:

In order for an Eligible Employee's coverage to take effect, the Eligible Employee must submit written application for coverage for himself and any Dependents. The Effective Date of coverage under this Policy is the date shown on the face page of the Policy.

Any person covered by a previous health plan of the Employer on the day prior to the Policy Effective Date, including any person who has continued group coverage under applicable federal or state law, is eligible on the Policy Effective Date.

Coverage under this Policy shall become effective on the Policy Effective Date for all existing Eligible Employees and Dependents upon completion of an application and election of coverage. This includes any Eligible Employee or Dependent who is confined in a Hospital or other institution. If the Policy is replacing coverage under a discontinued health plan, coverage for an Eligible Employee or Dependent may be delayed only until the expiration of any applicable extension of benefits provided by the previous health plan.

Initial Enrollment For New Eligible Employees:

If you apply for coverage within 31 days of your date of employment, your coverage will become effective on the first day of the month following the date that written application for coverage for you and any Dependents is received [and any Waiting Period has been satisfied. The **Waiting Period** is the length of time that you must be continuously employed before your coverage may become effective under the Policy. The Waiting Period under this Policy is [90] days from the first date of employment.]

If you do not enroll within 31 days of your employment date, coverage will become effective in accordance with the provisions for Late Enrollees.

Dependents:

If you have eligible Dependents on the date your coverage begins, your Dependents' coverage will begin on your Effective Date if:

1. you apply for Dependent coverage on or before your Effective Date; and
2. you pay the appropriate premium.

If you have Dependents who are not covered on the date your coverage begins and you subsequently apply for Dependent coverage, coverage for your Dependents will become effective in accordance with the provision for Late Enrollees.

Newly Acquired Eligible Dependents:

If you acquire new Dependents after the date your coverage begins, coverage for your Dependents will become effective in accordance with the following provisions:

Newborn Children:

Coverage will be automatic for the first 31 days following the birth of your newborn Child. To continue coverage beyond 31 days, you must notify Us and pay the required premium within that 30 day period. If you notify Us after that 30 day period, your newborn Child will become effective in accordance with the provisions for Late Enrollees. [If you decide not to continue coverage for your Dependent Child beyond the 31 day period, premium will be charged for the 31 days coverage was in force.]

Court Ordered Coverage for a Dependent:

If a court has ordered you to provide coverage for a spouse or minor Child, coverage will be automatic for the first 31 days following the date on which the court order is issued. To continue coverage beyond 31 days, you must notify Us and pay the required premium within that 31 day period. If you notify Us after that 31 day period, your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

Other Dependents:

Written application must be received within 31 days of the date that a spouse or Child first qualifies as an eligible Dependent. Coverage will become effective on the first day of the month following the date that application for coverage is received. If application is not made within the initial 31 days, then your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

If you have coverage for your spouse and existing children or coverage for existing children only, coverage for any additional children will become effective as of the date they become your Dependent provided that application for coverage is made within 31 days of eligibility.

If you ask that your Dependent be insured again after having canceled his or her coverage while your Dependent was still entitled to coverage, your Dependent's coverage will become effective in accordance with the provisions for Late Enrollees.

In no event will your Dependent's coverage become effective for coverage prior to your Effective Date.

Late Enrollees:

Late Enrollee means any Eligible Employee or Dependent who requests coverage in the 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 Effective Dates provision or otherwise in effect at the time of your employment date.

[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.]

Exceptions to Late Enrollee Provisions:

The Employee or Dependent will not be considered a Late Enrollee, if the Employee or Dependent did not apply for coverage within the Initial Enrollment Period and:

1. was covered under another Employer Health Benefit Plan during the Initial Enrollment Period; and
2. declined coverage under this Policy in writing on the basis of the coverage under another Employer Health Benefit Plan; and
3. coverage under the other Health Benefit Plan is terminating due termination of the plan, termination of employment, death of a spouse, or divorce.

The Employee or Dependent must apply within 31 days after the date coverage ends under another Employer Health Benefit Plan. If application is not requested within this 31 days, coverage for the Employee or Dependent will become effective in accordance with the provisions for Late Enrollees.

[PREEXISTING CONDITIONS

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be paid for a period of 12 months from the Insured Person's Effective Date of coverage.

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

Credit shall be given for the time the Insured Person was covered under a previous Health Benefit Plan if the previous Health Benefit Plan was in effect at any time during the 12 months before the Effective Date of coverage under this Policy.]

TERMINATION OF INSURANCE

Eligible Employees:

Your coverage will end on the earlier of:

1. the end of the last period for which premium payment has been made to Us, subject to the Grace Period provision of this Policy;
2. the date the Lifetime Maximum Benefits, if any, have been exhausted;
3. the date of fraud or misrepresentation of a material fact by you except as indicated in the Time Limit on Certain Defenses provision.

Dependents:

Your Dependent's coverage will end on the earlier of:

1. the date your coverage terminates (unless due to exhaustion of any Lifetime Maximum Benefits available to you);
2. the end of the period for which premium payment has been made to Us, subject to the Grace Period provisi n of this policy;
3. the date your Dependent no longer meets the definition of Dependent, as defined in the Policy;
4. the date Lifetime Maximum Benefits, if any, have been exhausted for the Dependent;
5. the date of fraud or misrepresentation of a material fact by the Dependent except as indicated in the Time Limit on Certain Defenses provision.

Company:

The Policy may be terminated by Us for non-payment of premiums, except as set out in the Grace Period provision of this Policy.

CONVERSION:

Any Dependent insured under this Policy whose coverage terminates because the Dependent no longer meets the definition of a Dependent shall be eligible for continuous coverage under a conversion policy with similar benefits at attained age then issued by Us. Written request for conversion together with payment of the first premium must be made within 31 days after such Dependent's coverage under this Policy has terminated.

Figure 22

GROUP PROVISIONS

PAYMENT OF PREMIUMS: Premiums are payable in advance. Premiums must be paid [monthly] including any contributions you must make. We may change the premium rates from time to time. We must give the Employer written notice of any premium rate change at least 31 days prior to the change. No premium rate change may be made on an individual basis.

TIME LIMIT ON CERTAIN DEFENSES:

Representations: All statements made by the [Policyholder or] Employer shall be considered representations and not warranties. We must provide the [Policyholder or] Employer with a copy of any statements used to contest coverage. All statements made by you shall be considered representations and not warranties. We must provide you or your Beneficiary with a copy of any statements used to contest coverage.

Misstatements on the application: After 2 years from the Policy Effective Date, we will not contest the validity of the Policy. After two years from your Certificate Effective Date, no misstatements on your application may be used to:

1. void this coverage, or
2. deny any claim for loss incurred or disability that starts after the 2 year period.

The above does not apply to fraudulent misstatements.

[Pre-Existing Conditions: After one year from the Certificate Effective Date, We will not reduce or deny any claim under the Policy because an Illness or Injury existed before the Certificate Effective Date.]

THE CONTRACT BETWEEN YOU AND US

Entire contract and changes: The entire contract between the Policyholder and Us is as stated in the Policy. No change in the Policy will be effective until approved by one of Our officers. This approval must be noted on or attached to the Policy. No agent may change the Policy or waive any of its provisions.

2055 GRP

THE CLAIMS PROCESS

1. Within 20 days after you receive Covered Services, or as soon as reasonably possible, you or someone on your behalf, must notify Us in writing of your claim.

2. Within 15 days after We receive your written notice of claim, We must:

   a. acknowledge receipt of the claim;
   b. begin any investigation of the claim;
   c. specify the information you must provide to file proof of loss. (We can request additional information during the investigation, if necessary); and
   d. send you any forms We require for filing proof of loss. If We do not send you the forms within this time period, you can file proof of loss by giving Us a letter describing the occurrence, the nature and the extent of your claim. You must give Us this letter within the time period for filing proof of loss.

3. Within 90 days after you receive Covered Services, you must send Us written proof of loss. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny your claim for being late if the proof is filed as soon as reasonably possible. Unless the Insured Person is not legally capable, the required proof must always be given to Us no later than one year from the date otherwise required.

4. Within 15 business days after We receive all the information required to secure final proof of loss, We must:

   a. give you written notice that your claim or part of your claim has been accepted and pay benefits within five business days after We notify you of Our acceptance; or
   b. give you written notice that your claim has been rejected and tell you the reason(s) for the rejection; or
   c. give you written notice if We need more time to make Our decision and the reasons We need additional time. However, We must notify you of Our final decision within 45 days.

5. If payment of the claim or part of the claim requires the performance of an act by you, We will pay within five business days after the date you perform the act.

TIME OF PAYMENT OF CLAIMS: We will pay benefits for any loss covered by the policy within 60 days upon receipt of written proof of loss.

PAYMENT OF CLAIMS:

Payment to You, Your Beneficiary, Your Estate: Benefits will be paid to you. Any benefits that are unpaid at your death will be paid either to the Beneficiary or to your estate if no Beneficiary is named.

If benefits are payable to your estate or to You or to a Beneficiary who cannot execute a valid release, We may pay benefits up to $1,000 to someone related to you or a Beneficiary by blood or marriage whom We deem to be equitably entitled to such benefits. We will be discharged to the extent of any such payments made by Us in good faith.

[**Payment to Assignee**: We will recognize any assignment made under the policy, if:

1. it is duly executed on a form acceptable to Us; and
2. a copy is on file with Us.

We assume no responsibility for the validity or effect of an assignment.]

[For Chapter 20 Companies Only:
Assignment: The rights and benefits of this Policy may not be assigned at any time.]

Payment to a Managing Conservator: Benefits paid on behalf of a covered Dependent Child may be paid to a person who is not the Employee, if an order issued by a court of competent jurisdiction in this or any other state names such person the managing conservator of the Child.

To be entitled to receive benefits, a managing conservator of a Child must submit to Us with the claim form, written notice that such person is the managing conservator of the Child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Employee where the Employee has paid any portion of a medical bill that would be covered under the terms of the Policy.

Payment to the Texas Department of Human Services: When services are paid for or rendered by the Texas Department of Human Services on behalf of You or a Dependent, payment for the services will be made directly

to the Texas Department of Human Services. In the case of a Dependent Child, when services are paid or rendered by the Texas Department of Human Services on behalf of such Dependent Child, payment for the services will be made directly to the Texas Department of Human Services if:

1. the parent who is an Employee is:

   a. a possessory conservator of the Child under an order issued by a court in this state or is not entitled to possession of or;
   b. access to the Child; and is required by court order or court-approved agreement to pay child support;

2. the Texas Department of Human Services is paying benefits on behalf of the Child under Chapter 31 or Chapter 32, Human Resources Code; and

3. We are notified through an attachment to the claim for insurance benefits when the claim is first submitted to us that the benefits must be paid directly to the Texas Department of Human Services.

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, you will not have to pay for it.

LEGAL ACTIONS: You cannot sue on any claim before 60 days after written proof of loss has been given as required. You cannot sue on any claim after 3 years from the time written proof of loss is required to be given.

EXTENSION OF BENEFITS: If an Insured Person is Totally Disabled on the date of termination of the Policy, coverage will be extended. Benefits will continue to paid under the terms of the Policy for Eligible Expenses due to the disabling condition. Extension of benefits will continue until the earlier of: a) the date payment of the maximum benefits occurs, b) the date the Insured Person ceases to be Totally Disabled, or c) the end of 90 days following the date of termination. This Extension of Benefits is not applicable if the policy is replaced by another carrier providing substantially equivalent or greater benefit.

Totally Disability or Totally Disabled means:

1. As applied to an Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of his

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

2. As applied to a Dependent, confinement as a bed patient in a Hospital.

Except as provided here, no benefits are payable for expenses incurred after the date of any termination of coverage. For information about the right to continue or convert coverage, refer to the Continuation/Conversion provision.

[GRACE PERIOD: There is a 31 day Grace Period allowed for the payment of each premium after the first premium. During this period coverage will remain in force. If the premium is not paid during the Grace Period, coverage will terminate at the end of the Grace Period. This is called a lapse.]

[DIVIDENDS: The Policy is a participating Policy. This means that the Policy will receive its share of any divisible surplus as determined each year by Us. This share will be credited as a dividend and paid to the Employer. Payment of any dividend directly to the Employer discharges Us from all liability for the payment of dividends].

MISSTATEMENT OF AGE: If the age of an Insured Person has been misstated and if the amount of premium is based on age, an adjustment of premiums shall be made based on the Insured Person's true age.

If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Insured Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.

[RIGHT TO RECOVERY/CLERICAL ERROR:

1. If We make benefit payments in excess of the benefits payable under the provisions of the Policy, We have the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.]

2. Clerical error by the policyholder will not end coverage or continue coverage that has ceased. In the event of such error, a premium adjustment will be made. However, such adjustment will not be made beyond the preceding renewal date of the Plan.]

[SUBROGATION: When We pay benefits under the Policy and it is determined that a negligent third party is liable for the same expenses, We have the right to subrogate from the monies payable from the negligent third party equal to the amount We have paid for such expenses. The Insured hereby agrees to reimburse

Us from any monies recovered from a negligent third party as a result of a judgment against, settlement with or otherwise paid by the third party. The Insured Person agrees to take action against the third party, furnish all information and provide assistance to Us regarding the action taken, and execute and deliver all documents and information necessary for Us to enforce our rights of subrogation.]

Figure 23

INDIVIDUAL PROVISIONS

THE CONTRACT BETWEEN YOU AND US:

Entire contract and changes: The entire contract between You and Us is as stated in this Policy, your application and any attached papers. No change in this Policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES:

Misstatements on your application: After 2 years from the Policy's Effective Date no misstatements in your application may be used to:

1. void this Policy, or
2. deny any claim for loss incurred or disability that starts after the 2 year period.

This does not apply to fraudulent misstatements.

[**Pre-existing Conditions:** After one year from your Effective Date, We will not reduce or deny any claim under this Policy because an Illness or Injury existed before your Effective Date.]

GRACE PERIOD: There is a 31 day Grace Period allowed for the payment of each premium after the first premium. During this period the Policy will remain in force. If the premium is not paid during the Grace Period, the Policy will terminate at the end of the Grace Period. This is called a lapse.

HOW TO PUT THIS POLICY BACK IN FORCE:

Reinstatement: Once the Policy lapses, We may or may not put it back in force (reinstate) at Our option. Our acceptance of a late premium without requiring an application for reinstatement will reinstate the Policy.

2055 IRP

If We require an application for reinstatement, You will be given a conditional receipt for the premium. If We approve the application, the Policy will be reinstated on the approval date. If We do not give you prior written notice of our disapproval, the Policy will be reinstated on the 45th day after the date of the conditional receipt.

After reinstatement, this Policy will cover only losses that result from an Injury sustained after the date of reinstatement or an Illness that begins more than 10 days after such date. In all other respects your rights and Our rights will stay the same, subject to any provisions that are endorsed on or attached to this Policy at the time of reinstatement. You will be charged up to 60 days of past due premiums.

THE CLAIMS PROCESS:

1. Within 20 days after you receive Covered Services, or as soon as reasonably possible, you or someone on your behalf, must notify Us in writing of your claim.

2. Within 15 days after We receive your written notice of claim, We must:

   a. acknowledge receipt of the claim;
   b. begin any investigation of the claim;
   c. specify the information you must provide to file proof of loss. (We can request additional information during the investigation, if necessary); and
   d. send you any forms We require for filing proof of loss. If We do not send you the forms within this time period, you can file proof of loss by giving Us a letter describing the occurrence, the nature and the extent of your claim. You must give Us this letter within the time period for filing proof of loss.

3. Within 90 days after you receive Covered Services, you must send Us written proof of loss. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny your claim for being late if the proof is filed as soon as reasonably possible. Unless the Insured Person is not legally capable, the required proof must always be given to Us no later than one year from the date otherwise required.

4. Within 15 business days after We receive all the information required to secure final proof of loss, We must:

   a. give you written notice that your claim or part of your claim has been accepted and pay benefits within five business days after We notify you of Our acceptance; or
   b. give you written notice that your claim has been rejected and tell you the reason(s) for the rejection; or
   c. give you written notice if We need more time to make Our decision and the reasons We need additional time. However, We must notify you of Our final decision within 45 days.

5. If payment of the claim or part of the claim requires the performance of an act by you, We will pay within five business days after the date you perform the act.

TIME OF PAYMENT OF CLAIMS: We will pay benefits for any loss covered by this Policy immediately upon receipt of written proof of loss.

PAYMENT OF CLAIMS:

Payment to You, Your Beneficiary, Your Estate: Benefits will be paid to You. Any benefits that are unpaid at your death will be paid either to the Beneficiary or to your estate, if no Beneficiary is named.

If benefits are payable to your estate or to You or to a Beneficiary who cannot give a valid release, we may pay benefits up to $1,000 to someone related to You or a Beneficiary by blood or marriage whom We deem to be equitably entitled to such benefits. We will be discharged to the extent of any such payments made by Us in good faith.

[**Payment to Assignee:** We will recognize any assignment made under the policy, if:

1. it is duly executed on a form acceptable to Us; and
2. a copy is on file with Us.

We assume no responsibility for the validity or effect of an assignment.]

[For Chapter 20 Companies Only: Assignment: The rights and benefits of the Policy may not be assigned at any time.]

Payment to the Texas Department of Human Services: When services are paid for or rendered by the Texas Department of Human Services on behalf of You or a Dependent, payment for the services will be made directly to the Texas Department of Human Services. In the case of a Dependent Child, when services are paid or rendered by the Texas Department of Human Services on behalf of such Dependent Child, payment for the services will be made directly to the Texas Department of Human Services if:

1. the parent who is an Employee is:

   a. a possessory conservator of the Child under an order issued by a court in this state or
   b. is not entitled to possession of or access to the Child and is required by court order or court-approved agreement to pay child support;

2. the Texas Department of Human Services is paying benefits on behalf of the Child under Chapter 31 or Chapter 32, Human Resources Code; and

3. We are notified through an attachment to the claim for insurance benefits when the claim is first submitted to us that the benefits must be paid directly to the Texas Department of Human Services.

PHYSICAL EXAMINATIONS AND AUTOPSY: We have the right to require a medical examination, at reasonable intervals, or an autopsy, where not prohibited by law, when a claim is made. If an examination or autopsy is required, you will not have to pay for it.

LEGAL ACTIONS: You cannot sue on any claim before 60 days after written proof of loss has been given as required. You cannot sue on any claim after 3 years from the time written proof of loss is required to be given.

CHANGE OF BENEFICIARY: Unless you have named an irrevocable Beneficiary, you have the right to change the Beneficiary, make or change assignment of benefits or change any part of your Policy.

PAYMENT OF PREMIUMS: The premium mode shown on the Data Page shows how often premiums are to be paid. After the first premium, each premium is due at the end of the period of which the prior premium was paid.

EXTENSION OF BENEFITS: Termination of this Policy will not affect the payment of benefits for any continuous loss that began while the Policy was in force. Benefits will continue to be paid under the terms of the Policy limited to

the duration of the Policy benefit period, payment of the maximum benefits or a time period of not less than three months. Except as provided here, no benefits are payable for expenses incurred after the date of any termination of coverage.

SPOUSE, THE INSURED: In the event you should die while this Policy is in force, your spouse, if insured under this Policy, will become the Policyholder.

[CANCELLATION: You may cancel this Policy at any time by sending Us written notice. Your Policy will be canceled as of the date of the next premium is due. The cancellation will not affect the payment of benefits for any continuous loss that began prior to the effective date of the cancellation.]

[DIVIDENDS: This Policy is a participating Policy. This means that the Policy will receive its share of any divisible surplus as determined each year by Us. This share will be credited as a dividend and paid to you. Payment of any dividend directly to you the Insured Person discharges Us from all liability for the payment of dividends.]

[MISSTATEMENT OF AGE: Your age may have been misstated in your application. If so, We will pay the benefits that your premiums would have purchased at your true age. If the Policy would not have become effective at your true age, We will be liable only for a refund of all premiums paid.]

[RIGHT TO RECOVERY: If We make benefit payments in excess of the benefits payable under the provisions of this Policy, We have the right to recover such excess from any persons to, or for, or with respect to whom, such payments were made.]

[SUBROGATION: When We pay benefits under this Policy and it is determined that a negligent third party is liable for the same expenses, We have the right to subrogate from the monies payable from the negligent third party equal to the amount We have paid for such expenses. The Insured Person hereby agrees to reimburse Us from any monies recovered from a negligent third party as a result of a judgment against, settlement with or otherwise paid by the third party. The Insured Person agrees to take action against the third party, furnish all information and provide assistance to Us regarding the action taken, and execute and deliver all documents and information necessary for Us to enforce Your rights of subrogation.]

[UNPAID PREMIUMS: When We pay a claim, We will deduct any premium and unpaid from the claim payment.]

PROTOTYPE FORMS FOR PRESCRIBED BENEFITS

Preventive and Primary Care Benefit Plan

Schedules of Benefits (Non-PPO and PPO)
Policy Definitions
Benefits Provided
Exclusions and Limitations
Prescription Drug Benefit Rider

In-Hospital Benefit Plan

Schedules of Benefits (Non-PPO and PPO)
Policy Definitions
Benefits Provided
Exclusions and Limitations
Supplementary Accidental Injury Benefit Rider
Preventive and Primary Care Benefit Rider

Standard Health Benefit Plan

Schedules of Benefits (Non-PPO and PPO)
Policy Definitions
Benefits Provided
Exclusions and Limitations
Alternate Benefits for Chemical Dependency

Forms Common to More Than One Plan

Alternate Cost Containment Provisions
Continuation/Conversion
Coordination of Benefits
Preferred Provider Provisions
Chemical Dependency Benefit Waiver Rider

Outlines of Coverage

PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

Figure 24

SCHEDULE OF BENEFITS
PREVENTIVE AND PRIMARY CARE BENEFIT PLAN
(Non-PPO Plan)

Policy Year Deductible	[$100] [$250]
Policy Year Copayment Maximum	$1,000 per individual $3,000 per family
Policy Year Maximum Benefit	$15,000 per individual
Lifetime Maximum Benefit	unlimited

COVERED SERVICES	PERCENTAGE PAYABLE
Inpatient Hospital Expense Benefit Subject to the Policy Year Deductible and limited to Maximum of 5 days per Policy Year	80%
Outpatient Expense Subject to Policy Year Deductible (includes outpatient Hospital, outpatient clinic or office visits for treatment of an Illness or Injury)	80%
Diagnostic Exams, Labs and X-rays Subject to Policy Year Deductible and limited to Maximum of $5,000 per Policy Year	80%
Chemical Dependency Benefits*** Subject to Policy Year Deductible Inpatient Hospital Expense limited to Maximum of 5 days per Policy Year Outpatient Expense limited to Maximum of 40 visits per Policy Year	80%

*** Unless waiver attached

2055 SCH.PP

Mental Health Services Subject to Policy Year Deductible Inpatient Hospital Expense limited to Maximum of 5 days per Policy Year Outpatient Expense limited to Maximum of 40 visits per Policy Year	80%
Emergency Care Benefit Subject to Policy Year Deductible	80%
Maternity Benefit Subject to Policy Year Deductible	80%
Preventive Care Benefit Policy Year Deductible and Copayment waived. Includes Childhood Immunizations, pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/hearing testing for children under the age of 19.	100%
Well Child Care Subject to Policy Year Deductible (except for services covered under the Preventive Care Benefit)	80%
Annual Physical Examination Subject to Policy Year Deductible (except for services covered under the Preventive Care Benefit)	80%
Home Health Benefit Subject to the Policy Year Deductible and limited to Maximum of 40 visits per Policy Year	80%
Therapy Benefit Subject to the Policy Year Deductible and limited to Maximum of 40 visits per Policy Year for physical, occupational and/or speech therapy (includes diagnostic services)	80%

[Prescription Drug Benefit Rider Subject to the Policy Year Deductible]	[50%]

or

[Prescription Drug Card Program Rider
Plan pays 100% after the Deductible

Deductible	
Generic drug --	[$8] per prescription or refill
Name Brand Drug --	[$12] per prescription or refill]

Figure 25

SCHEDULE OF BENEFITS
PREVENTIVE AND PRIMARY CARE BENEFIT PLAN
(PPO PLAN)

[Policy Year Deductible or Non-Preferred Provider Policy Year Deductible]	[$100] [$250]
[Preferred Provider Policy Year Deductible]	[ ]
[Per Visit Deductible]	[$10] [$15]
Policy Year Copayment Maximum	$1000 per individual $3000 per family [Preferred Provider and Non-Preferred Provider Combined]
Policy Year Maximum Benefit	$ 15,000
Lifetime Maximum Benefit	unlimited

COVERED SERVICES	PERCENTAGE PAYABLE PPO	PERCENTAGE PAYABLE NON-PPO
Inpatient Hospital Expense Benefit	[100%] [90%]	80%
Limited to Maximum of 5 days per Policy Year	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[Subject to Policy Year Deductible] or Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Outpatient Expense	[100%] [90%]	80%
(includes outpatient Hospital, outpatient clinic or office visits for treatment of an Illness or Injury)	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]

2055 SCHPO.PP

Diagnostic Exams, Labs and X-rays Limited to Maximum of $5,000 per Policy Year	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80% [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Chemical Dependency Benefits*** Inpatient Hospital Expense limited to Maximum of 5 days per Policy Year Outpatient Expense limited to Maximum of 40 visits per Policy Year	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80% [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Mental Health Services Inpatient Hospital Expense limited to Maximum of 5 days per Policy Year Outpatient Expense limited to Maximum of 40 visits per Policy Year	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80% [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Emergency Care Benefit	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]

*** Unless waiver attached

Maternity Benefit	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80% [Subject to Policy Year Deductible or [Subject to Non-Preferred Provide Deductible] or [Deductible waived]
Preventive Care Benefit	100%	100%
Policy Year Deductible waived. Includes Childhood Immunizations, pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/hearing testing for children under the age of 19.	No Deductible	No Deductible
Well Child Care (except for services covered under the Preventive Care Benefit)	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80 % [Subject to Policy Year Deductible] or [Subject to Non-Preferred Pro Deductible] or [Deductible waived]
Annual Physical Examination (except for services covered under the Preventive Care Benefit)	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80 % [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]

ome Health Benefit	[100%] [90%]	80%
Limited to Maximum of 40 visits per Policy Year	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Deductible waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Therapy Benefit	[100%] [90%]	80%
Limited to Maximum of 40 visits per Policy Year for physical, occupational and/or speech therapy (includes diagnostic services)	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]

[PRESCRIPTION DRUG CARD PROGRAM
Plan pays 100% after Deductible

Deductible
Generic drug - [$ 8] per prescription or refill
Name Brand - [$12] per prescription or refill]

or

[PRESCRIPTION DRUG BENEFIT
Percentage Payable [50%]
Subject to the Policy Year Deductible]

Figure 26

POLICY DEFINITIONS
PREVENTIVE AND PRIMARY CARE BENEFIT PLAN

Affiliated Employer means a person connected by commonality of 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 and discharged from within a twenty-four (24) hour period.

Beneficiary means the person you designate to receive any unassigned benefits that are paid after your death.

[Certificate of Insurance means the individual certificate issued to the Insured Person which describes the coverage provided by the Policy.]

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

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which 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 Hospitals; or
3. licensed as a chemical dependency treatment program by the Texas Commission on Alcohol or 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.

2055 DEF.PP

Child means the unmarried:

1. natural Child of the Insured Person including a newborn Child;
2. adopted Child including a Child who the Insured Person is seeking to adopt;
3. natural Child or adopted Child of the Insured Person's spouse provided the Child resides with the Insured Person.

Childhood Immunizations means a test for tuberculosis, immunization and re-immunization against diphtheria, tetanus, poliomyelitis, *Haemophilus influenzae type b,* measles, mumps, rubella, and hepatitis B.

Complication of Pregnancy means:

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

[For Chapter 20 Companies only:
Contracting Facility means a Hospital, a Facility Other Provider or any other facility that We have a written contract with to provide care, services or supplies that are covered by the Policy. A Contracting Facility also means a Hospital or Facility Other Provider located outside of Texas, that another insurance company has a contract with that allows us to use its facilities.]

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

Dependent means:

1. a spouse;
2. a newborn Child;
3. a Child under the age of 19 years;
4. a Child who is a full-time student under the age of 23 years and who is financially dependent upon the parent;
5. a Child of any age who is medically certified as disabled and dependent on the parent;
6. an adopted Child,
7. a grandchild who is your dependent for federal income tax purposes.

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

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

Employee means you, the principal insured, hereafter referred to as "you".

Employer means an individual, corporation, partnership, association, or other private legal entity 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 whom were employed in this state. [Employer includes Employer members of an association that meets the criteria defined above.]

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 definition of Medically Necessary to resolve a dispute regarding Experimental treatment.

Generic means drugs not protected by a trademark registration.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provide by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. Reinsurance contracts issued on a stop-loss, quota-share, or similar basis.

Hospital means:

1. a facility that
   a. is licensed as a Hospital and operated pursuant to law;
   b. is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians, medical diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made;
   c. provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.);
   d. maintains and operates a minimum of five beds;
   e. has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis;
   f. maintains permanent medical history records; or
2. a facility that
   a. is accredited by the Joint Commission on Accreditation of Healthcare Organizations and
   b. offers medical therapeutic, and psychiatric care for the treatment of Chemical Dependency.

The major surgery facility requirement is hereby waived for facilities that specialize in treating the mentally ill.

Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.

Illness means sickness, disease, pregnancy, or Complications of Pregnancy that are first manifested after the Effective Date of insurance and while the Policy is in force.

Injury or Accidental Injury means accidental bodily Injury sustained by an Insured Person that is the direct cause of the loss independent of disease, bodily infirmity or any other cause and occurs while the Policy is in force.

Insured Person means you and/or your Dependents, if insured under the Policy.

Low-Dose Mammography means the X-ray examination of the breast using equipment dedicated specifically for mammography including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid breast, with two views for each breast.

Medically Necessary means 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 may appeal any decision We make to deny your claim or any part of your claim. Our written notice of denial will include the reasons for the denial, including any documentation that We used in making Our decision.

You or your Physician, Provider or Other Healthcare Practitioner acting on your behalf may submit additional information to Us and request reconsideration of the claim.

If We have not given you an answer within 15 days or We again deny your claim or any part of your claim, you may 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 mediation or arbitration, and We will pay the remainder of the cost.

[For Chapter 20 Companies Only:
Noncontracting Facility means a Hospital, a Facility Other Provider or any other facility that We do not have a written contact with.]

Physician means a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) other than an Insured Person or a person related to the Insured Person, who is practicing within the scope of his or her license.

[Policyholder means the Employer.]
[Policyholder means the Association.]
[Policyholder means the Trustee of a Multiple Employer Trust.]

[Policy Year means a 365 day period that begins on the Policy's Effective Date.]
[Policy Year means a period of one full calendar year.]

[Preexisting Condition means 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

In addition, Preexisting Condition also includes any pregnancy existing on the Effective Date.]

Provider or Other Health Care Practitioner a duly licensed or certified practitioner of the healing arts including, but not limited to, a Physician's assistant or an advanced nurse practitioner, who is acting within the scope of said license or certificate.

Reasonable and Customary means 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 or 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; and
2. whose Illness or Injury is comparable in nature and severity.

You may provide your own estimate of the Reasonable & Customary charge by surveying providers in your area and request that We reconsider Our determination.

You may use the appeals process under the definition of Medically Necessary to resolve a dispute regarding Reasonable and Customary charges.

Schedule of Benefits means the benefit schedule set forth in the Policy or Certificate.

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).

Figure 27

BENEFITS PROVIDED
Preventive and Primary Care Benefit Plan

If you or your Dependent incur expense for Covered Services while covered under the Policy, We will pay a percentage of that Eligible Expense after the Deductible is satisfied. We will pay up to the Maximums for each Insured Person. The Percentage Payable, Deductible, and Maximums are shown in the Schedule of Benefits.

Deductible means the amount of Eligible Expenses shown in the Schedule of Benefits for each Insured Person for which We will pay no benefits during each Policy Year.

Copayment means, after the Deductible has been met, the amount you must pay for Eligible Expenses under the Policy. Copayment does not include any services or charges which are not covered under the Policy, the Deductible, or Covered Services under any attached rider.

The **Individual Policy Year Copayment Maximum** for an Insured Person is $1,000. After the Copayments for an Insured Person equal $1,000 in one Policy Year, the Percentage Payable will increase to 100% for the remainder of that Policy Year.

The **Family Policy Year Copayment Maximum** for Insured Persons within one family is $3,000. If Copayments for you and your Dependents equal $3,000 in one Policy Year, the Percentage Payable for those Insured Persons within that family will increase to 100% for the remainder of the Policy Year. No Insured Person will be required to satisfy more than the Individual Policy Year Copayment Maximum.

Policy Year Maximum means the maximum benefit payable per Insured Person in a Policy Year.

Lifetime Maximum means the maximum benefit payable per Insured Person's lifetime.

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Eligible Expenses are charges for Covered Services to the extent that they are:

1. not in excess of the Reasonable and Customary charge for the treatment, service, or supply and

   a. Medically Necessary for the diagnosis or treatment of an Illness or Injury; or
   b. covered preventive care services; and

2. covered by the Policy.

Covered Services are:

1. Inpatient Hospital services for up to five days per policy year for:

   a. Daily room and board and general nursing services in an amount equal to the average semi-private room rate. Charges made by a Hospital for a private room will be considered an Eligible Expense in the amount not greater than the average semi-private room rate;
   b. Confinement in an intensive care or cardiac care unit to a maximum of three times the average semi-private room rate;
   c. 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, blood when not replaced and its administration.

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

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

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

5. Assistant surgery fee (not to exceed 25% of the primary surgeon's fee for any one assistant) when the procedure requires an assistant surgeon(s) due to medical necessity.

6. anesthesia and its administration.

7. 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.

8. Emergency care services including:

   a. inpatient Hospital services;
   b. outpatient Hospital services;
   c. professional ground or air ambulance services for transportation to nearest Hospital equipped to treat the Illness or Injury;
   d. Physician services for an operation, or the repair of a dislocation or fracture; including the services of an assisting surgeon;
   e. anesthesia and its administration; and
   f. services for medical care provided by a Physician, Provider or Other Health Care Practitioner (if not included in d).

   Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by 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 Insured Person'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 under the definition of Medically Necessary to resolve a dispute regarding Emergency Care.

9. 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.

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

11. Home health care services under a plan of care established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending 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. medical social services;
d. intravenous therapy;
e. dialysis;
f. service provided by unlicensed personnel under the delegation of a licensed health professional;
g. the furnishing of medical equipment and medical supplies other than drugs and medicine; and
h. nutritional counseling.

The comprehensive limitations listed in the Policy will apply to home health care services. In addition, comprehensive covered charges will not include charges for:

a. services or supplies not included in the home health care plan;
b. services of any person who normally lives in your home is a member of the Insured Person's Immediate Family (you, your spouse, your parent, brother or sister;
c. custodial care (services or supplies provided to assist a person in daily living...e.g., meals and personal grooming); or
d. transportation services.

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.

We may waive the Policy Year limit on home health services 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 shown in the Schedule of Benefits.

12. Mental Health Services (including Serious Mental Illness) for:

a. outpatient evaluation;
b. crisis intervention; and
c. services for treatment.

Benefits will be limited to:

a. eligible inpatient Hospital services for up to five (5) days per Policy Year; and
b. outpatient services limited to 40 visits per Policy Year.

13. Evaluation and treatment for Chemical Dependency limited to:

a. eligible inpatient services in a Hospital or a Chemical Dependency Treatment Center for up to five days per Policy Year including:

1. room and board; and
2. miscellaneous services and supplies, and

b. outpatient treatment for a maximum of 40 visits per Policy Year.

14. Well child care including but not limited to:

a. ophthalmologic examination for infants at risk for eye problems;
b. child health supervision services 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;

Covered child health supervision services include:

1. history;
2. physical examination;
3. developmental assessment;
4. anticipatory guidance;
5. appropriate childhood immunizations;
6. laboratory testing;
7. hearing and vision screening.

Charges for Childhood Immunizations will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived. Remaining covered well child care expenses will be payable as shown on the Schedule of Benefits.

In addition, Covered Services will include annual vision and hearing testing for any covered Child under the age of 19. Eligible Expenses will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived.

15. Rental or purchase price, 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;

16. Oxygen and the rental of equipment for its administration;

17. One annual physical examination. Services include:

    a. history;
    b. physical examination;
    c. 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 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 Expenses will be payable at 100% of the Reasonable and Customary charge and the Deductible and Copayment will be waived.

Figure 28

EXCLUSIONS AND LIMITATIONS
PREVENTIVE AND PRIMARY CARE BENEFIT 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 and 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. Any treatment provided by any Immediate Family Member (you, your spouse, your parent, brother, or sister) or provided by your Employer.

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

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

h. Any act of war, declared or undeclared.

i. 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.

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

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

l. 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.

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

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

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

y. 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.

z. Any service or supply in connection with any transplant.

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

bb. 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.

cc. Transportation, except for local ground ambulance service or air ambulance service to nearest Hospital equipped to treat the Illness or Injury as needed for Emergency Care.

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

ee. 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.

ff. 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.

gg. Any medical social services or vocational counseling.

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

[For Chapter 20 companies only:

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

jj. 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 29

PRESCRIPTION DRUG BENEFIT RIDER

This rider is made a part of the Policy/Certificate to which it is attached. The rider is subject to all provisions, terms, definitions and limitations of the Policy which are not in conflict with the provisions of this rider.

DEFINITIONS:

Generic means a drug not protected by a registered trademark.

Name Brand means a drug protected by a registered trademark.

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:

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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;

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 & 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 prescribed for an Injury or Illness arising out of employment;

17. 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.

IN-HOSPITAL BENEFIT PLAN

Figure 30

SCHEDULE OF BENEFITS
IN-HOSPITAL BENEFIT PLAN
(Non-PPO Plan)

Hospital Deductible Per One Period of Hospital Confinement	[$100] [$250]
Policy Year Copayment Maximum	[$ 2,000] [$5,000] per individual
Policy Year Maximum Benefit	$ 100,000
Lifetime Maximum Benefit	$1,000,000

COVERED SERVICES	PERCENTAGE PAYABLE
Inpatient Hospital Expense Benefit	80%
Mental Illness or Chemical Dependency	50%
Outpatient Follow-up Care	80%
(Eligible Expenses limited to 90 days after the date of discharge)	
[Supplementary Accidental Injury Benefit Rider	$ 500
(Eligible Expenses must be incurred within 90 days of the Injury)]	

2055 SCH.IH

Figure 31

SCHEDULE OF BENEFITS
IN-HOSPITAL BENEFIT PLAN
(PPO Plan)

[Hospital Deductible Per One Period of Hospital Confinement or Hospital Non-Preferred Provider Deductible Per One Period of Hospital Confinement]	[$100] [$250]
[Hospital Preferred Provider Deductible Per One Period of Hospital Confinement]	[ ]
Policy Year Copayment Maximum	[$ 2,000][$5,000] (per individual) [Preferred Provider and Non-Preferred Provider Combined]
Policy Year Maximum Benefit	$ 100,000 (per individual)
Lifetime Maximum Benefit	$1,000,000 (per individual)

COVERED SERVICES	PERCENTAGE PAYABLE PPO	PERCENTAGE PAYABLE NON-PPO
Inpatient Hospital Expense Benefit	[100%] [90%] [Subject to Hospital Deductible] or [Hospital Deductible per confinement waived when confined in Preferred Provider hospital] or [Subject to Hospital Preferred Provider Deductible]	[80%] [70%] [Subject to Hospital Deductible] or [Subject to Hospital Non-Preferred Provider Deductible] or [Deductible waived]

2055 SCHPO.IH

Mental Illness or Chemical Dependency	[80%] [70%] [Subject to Hospital Deductible] or [Hospital Deductible per confinement waived when confined in Preferred Provider Hospital] or [Subject to Hospital Preferred Provider Deductible]	50% [Subject to Hospital Deductible] or [Subject to Hospital Preferred Provider Deductible] or [Deductible waived]
Outpatient Follow-up Care (Eligible Expenses limited to 90 days after the date of discharge)	[100%] [90%]	[80%] [70%]
[Supplementary Accidental Injury Benefit Rider (Eligible Expenses must be incurred within 90 days of the Injury)]		$ 500

Figure 32

[SCHEDULE OF BENEFITS
PREVENTIVE AND PRIMARY CARE BENEFIT RIDER
(Non-PPO Plan)

Policy Year Deductible	[$100] [$250]
Policy Year Copayment Maximum	$1,000 per individual $3,000 per family
Policy Year Maximum Benefit	$15,000 per individual
Lifetime Maximum Benefit	unlimited

COVERED SERVICES	PERCENTAGE PAYABLE
Outpatient Expense Subject to Policy Year Deductible (includes outpatient Hospital, outpatient clinic or office visits for treatment of an Illness or Injury)	80%
Diagnostic Exams, Labs and X-rays Subject to Policy Year Deductible and limited to Maximum of $5,000 per Policy Year	80%
Chemical Dependency Benefits Subject to Policy Year Deductible Outpatient Expense limited to Maximum of 40 visits per Policy Year	80%
Mental Health Services Subject to Policy Year Deductible Outpatient Expense limited to Maximum of 40 visits per Policy Year	80%

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Emergency Care Benefit Subject to Policy Year Deductible	80%
Maternity Benefit Subject to Policy Year Deductible	80%
Preventive Care Benefit Policy Year Deductible and Copayment waived. Includes Childhood Immunizations, pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/hearing testing for children under the age of 19.	100%
Well Child Care Subject to Policy Year Deductible (except for services covered under the Preventive Care Benefit)	80%
Annual Physical Examination Subject to Policy Year Deductible (except for services covered under the Preventive Care Benefit)	80%
Home Health Benefit Subject to the Policy Year Deductible and limited to Maximum of 40 visits per Policy Year	80%
Therapy Benefit Subject to the Policy Year Deductible and limited to Maximum of 40 visits per Policy Year for physical, occupational and/or speech therapy (includes diagnostic services)	80%

Figure 33

[SCHEDULE OF BENEFITS
PREVENTIVE AND PRIMARY CARE BENEFIT RIDER
(PPO Plan)

[Policy Year Deductible or Non-Preferred Provider Policy Year Deductible]	[$100] [$250]
[Preferred Provider Policy Year Deductible]	[ ]
[Per Visit Deductible]	[$15] [$10]
Policy Year Copayment Maximum	$1000 per individual $3000 per family [Preferred Provider and Non-Preferred Provider Combined]
Policy Year Maximum Benefit	$ 15,000
Lifetime Maximum Benefit	unlimited

COVERED SERVICES	PERCENTAGE PAYABLE PPO	PERCENTAGE PAYABLE NON-PPO
Outpatient Expense	[100%] [90%]	80%
(includes outpatient Hospital, outpatient clinic or office visits for treatment of an Illness or Injury)	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Diagnostic Exams, Labs and X-rays	[100%] [90%]	80%
Limited to Maximum of $5,000 per Policy Year	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]

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Chemical Dependency Benefits	[100%] [90%]	80%
Outpatient Expense limited to Maximum of 40 visits per Policy Year	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[Subject to Policy Year Dedu or [Subject to Non-Preferred Provid Deductible] or [Deductible waived]
Mental Health Services	[100%] [90%]	80%
Outpatient Expense limited to Maximum of 40 visits per Policy Year	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[Subject to Policy Year Deductible or [Subject to Non-Preferred Provide Deductible] or [Deductible waived]
Emergency Care Benefit	[100%] [90%]	[100%] [90%]
	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	[Subject to Policy Year Deductible or [Subject to Preferred Provide Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]

Maternity Benefit	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80% [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Preventive Care Benefit	100%	100%
Policy Year Deductible waived. Includes Childhood Immunizations, pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/hearing testing for children under the age of 19.	No Deductible	No Deductible
Well Child Care (except for services covered under the Preventive Care Benefit)	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80 % [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Annual Physical Examination (except for services covered under the Preventive Care Benefit)	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80 % [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]

Home Health Benefit Limited to Maximum of 40 visits per Policy Year	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Deductible waived]	80% [Subject to Policy Year Deductible or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]
Therapy Benefit Limited to Maximum of 40 visits per Policy Year for physical, occupational and/or speech therapy (includes diagnostic services)	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible waived]	80% [Subject to Policy Year Deductible or [Subject to Non-Preferred Provider Deductible] or [Deductible waived]

Figure 34

POLICY DEFINITIONS
IN-HOSPITAL BENEFIT PLAN

Affiliated Employer means a person connected by commonality of 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.

Beneficiary means the person you designate to receive any unassigned benefits that are paid after your death.

[Certificate of Insurance means the individual certificate issued to the Insured Person which describes the coverage provided by the Policy.]

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

Child means the unmarried:

1. natural Child of the Insured Person including a newborn Child;
2. adopted Child including a Child who the Insured Person is seeking to adopt;
3. natural Child or adopted Child of the Insured Person's spouse provided the Child resides with the Insured Person.

Complication of Pregnancy means:

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

Confinement or Confined means admission or admitted as a registered bed-patient in a Hospital upon the advice of a Physician.

[For Chapter 20 Companies only:
Contracting Facility means a Hospital, a Facility Other Provider or any other facility that We have a written contract with to provide care, services or supplies that are covered by the Policy. A Contracting Facility also means a Hospital or Facility Other Provider located outside of Texas, that another insurance company has a contract with that allows us to use its facilities.]

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

Dependent means:

1. a spouse;
2. a newborn Child;
3. a Child under the age of 19 years;
4. a Child who is a full-time student under the age of 23 years and who is financially dependent upon the parent;
5. a Child of any age who is medically certified as disabled and dependent on the parent;
6. an adopted Child,
7. a grandchild who is your dependent for federal income tax purposes

Educational means that the primary purpose of the service or supply is to provide the Insured Person with any of the following:

1. training in the activities of daily living;
2. instruction in scholastic skills such as reading and writing;
3. preparation for an occupation; or
4. treatment for learning disabilities.

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

In addition, in the case of a Hospital stay, charges will be considered "Educational" to the extent that We determine them to be allocable to the scholastic education or vocational training of the Insured Person.

Employee means you, the principal insured, hereafter referred to as "you".

Employer means an individual, corporation, partnership, association, or other private legal entity 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 whom were employed in this state.

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 sercives were provided.

You can use the appeals process under the definition of Medically Necessary to resolve a dispute regarding Experimental treatment.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provided by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. reinsurance contracts issued on a stop-loss, quota-share, or similar basis.

Hospital means:

1. a facility that
   a. is licensed as a Hospital and operated pursuant to law;
   b. is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians, medical diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made;
   c. provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.);
   d. maintains and operates a minimum of five beds;
   e. has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis;
   f. maintains permanent medical history records; or
2. a facility that
   a. is accredited by the Joint Commission on Accreditation and
   b. offers medical therapeutic, and psychiatric care for the treatment of Chemical Dependency.

The major surgery facility requirement is hereby waived for facilities that specialize in treating the mentally ill.

Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.

Illness means sickness, disease, pregnancy or Complications of Pregnancy that are first manifested after the Effective Date of insurance and while the Policy is in force.

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

Insured Person means you and/or your Dependents, if insured under the Policy.

Medically Necessary means 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 may appeal any decision We make to deny your claim or any part of your claim. Our written notice of denial will include the reasons for the denial, including any documentation that We used in making our decision.

You or your Physician, Provider or Other Healthcare Practitioner or another person acting on your behalf may submit additional information to Us and request reconsideration of the claim.

If We have not given you an answer within 15 days or we again deny your claim or any part of your claim, you may 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 mediation or arbitration, and We will pay the remainder of the cost.

[For Chapter 20 Companies only:
Noncontracting Facility means a Hospital, a Facility Other Provider or any other facility that We do not have a written contact with.]

One Period of Hospital Confinement means confinement within a Hospital as a resident bed patient for the treatment of an Injury or Sickness. All periods of Hospital confinement due to the same or related causes, not separated by [90], [120], [150], [180] days shall be considered One Period of Hospital Confinement.

Physician means a duly licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is practicing within the scope of his or her license.

[Policyholder means the Employer.]
[Policyholder means the Association.]
[Policyholder means the Trustee of a Multiple Employee Trust.]

[Policy Year means a 365 day period that begins on the Policy's Effective Date.
[Policy Year means a period of one full calendar year.]

[Preexisting Condition means 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.

In addition a Preexisting Condition will include any pregnancy existing on the Effective Date.**]**

Provider or Other Health Care Practitioner a duly licensed or certified practitioner of the healing arts, including but not limited to a physician's assistant or an advanced nurse practitioner, who is acting within the scope of said license or certificate.

Reasonable and Customary means 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 or 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; and
2. whose Illness or Injury is comparable in nature and severity.

You may provide your own estimate of the Reasonable and Customary charge by surveying providers in your area and request that We reconsider Our determination.

You may use the appeals process under the definition of Medically Necessary to resolve a dispute regarding Reasonable and Customary charges.

Schedule of Benefits means the benefit schedule set forth in the Policy or Certificate.

Figure 35

BENEFITS PROVIDED
IN-HOSPITAL BENEFIT PLAN

If you or your Dependent incur expense for Covered Services while confined in a Hospital, we will pay a percentage of that Eligible Expense after the Deductible is satisfied. We will pay up to the Maximums for each Insured Person. The Percentage Payable, Deductible, and applicable Maximums are shown in the Schedule of Benefits.

Deductible means the amount of Eligible Expenses shown in the Schedule of Benefits for each Insured Person for which We will pay no benefits during each One Period of Hospital Confinement.

Copayment means, after the Deductible has been met, the amount you must pay for Eligible Expenses under the Policy. Copayment does not include any services or charges which are not covered under the Policy, or the Deductible, or Covered Services provided under any attached rider.

The **Individual Policy Year Copayment Maximum** for an Insured Person is [$2,000] [$5,000]. After the Copayments for an Insured Person equal [$2,000] [$5,000] in one Policy Year, the Percentage Payable will increase to 100% for the remainder of that Policy Year.

Policy Year Maximum means the maximum benefit payable per Insured Person in a Policy Year.

Lifetime Maximum means the maximum benefit payable per Insured Person's lifetime.

Eligible Expenses are charges for Covered Services to the extent that they are:

1. Medically Necessary for the diagnosis, treatment or rehabilitative services of an Illness or Injury;

2. not in excess of the Reasonable and Customary charge for the treatment, service, or supply; and

3. covered by the Policy;

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Covered Hospital Services are:

1. services for hospital room and board including:
   a. average semi-private room
   b. intensive care unit/cardiac unit (up to three times the average semi-private room rate)
   c. general nursing services

2. 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.

3. diagnostic x-ray and laboratory tests and the interpretation thereof;

4. services made by Physicians or Other Health Care Practitioners for diagnosis, treatment, rehabilitative services, and surgery;

5. assistant surgeon's fees (not to exceed 25% of the primary surgeon's fee) when the procedure requires an assistant surgeon due to medical necessity; and

6. anesthesia and its administration.

Mental Illness and Chemical Dependency Benefits:

Eligible Expenses provided while confined in a Hospital for treatment of mental illness or Chemical Dependency will be limited to 50% of Covered Hospital Services.

Outpatient Follow-up Care:

Outpatient care necessary for recovery due to an inpatient Hospital stay is limited to Eligible Expenses received within 90 days from the date of discharge from the Hospital. Covered services include diagnostic, treatment, rehabilitative services, oxygen and the rental of equipment for its administration and 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. These services must be prescribed by the Physician.

Figure 36

EXCLUSIONS AND LIMITATIONS
IN-HOSPITAL BENEFIT 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 and 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 an Immediate Family Member (you, your spouse, your parent, brother or sister) or provided by the Employer.

j. Any act of war, declared or undeclared.

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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, 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.

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 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.

r. Services 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. Charges for prescription drugs or pharmaceuticals except when provided as an inpatient in a Hospital.

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

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.

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 including ambulance services.

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 septemic disease.

ff. Any medical social service 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 37

[SUPPLEMENTARY
ACCIDENTAL INJURY BENEFIT
RIDER

Supplementary Accidental Injury Benefit:

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;

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;

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

Figure 38

[PREVENTIVE AND PRIMARY CARE BENEFIT RIDER

This rider is made a part of the [Policy]/[Certificate] to which it is attached. The rider is subject to all provisions, terms, definitions, exclusions and limitations of the Policy which are not in conflict with the provisions of this rider.

DEFINITIONS:

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 with a twenty-four (24) hour peered.

Childhood Immunizations means a test for tuberculosis, immunization and re-immunization against diphtheria, tetanus, poliomyelitis, Haemophilus influenzae type b, measles, mumps, rubella, and hepatitis B.

Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by 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 under the definition of Medically Necessary to resolve a dispute regarding Emergency Care.

Low-Dose Mammography means the X-ray examination of the breast using equipment dedicated specifically for mammography including the X-ray tube, filter, compression device, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid breast, with two view for each breast.

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).

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BENEFITS PROVIDED:

If you or your Dependent incur expense for Covered Services, We will pay a percentage of that Eligible Expense after the Deductible is satisfied. We will pay up to the Maximums for each Insured Person. The Percentage Payable, Deductible, and Maximums are shown in the Schedule of Benefits. Such charges are payable only to the extent that they do not duplicate charges included under any other Eligible Expense provisions of the Policy. This rider will not duplicate benefits for Covered Services that are paid under the Policy.

Deductible means the amount of Eligible Expenses shown in the Schedule of Benefits for each Insured Person for which We will pay no benefits during each Policy Year.

Copayment means, after the Deductible has been met, the amount you must pay for Eligible Expenses under the Policy. Copayment does not include any services or charges which are not covered under the Rider, or the Deductible.

The **Individual Policy Year Copayment Maximum** for an Insured Person is $1,000. After the Copayments for an Insured Person equal $1,000 in one Policy Year, the Percentage Payable will increase to 100% for the remainder of that Policy Year.

The **Family Policy Year Copayment Maximum** for Insured Persons within one family is $3,000. If Copayments for an Employee and covered Dependents equal $3,000 in one Policy Year, the Percentage Payable for those Insured Persons within that family will increase to 100% for the remainder of the Policy Year. No Insured Person will be required to satisfy more than the Individual Policy Year Copayment Maximum.

Policy Year Maximum means the maximum benefit payable per Insured Person in a Policy Year.

Lifetime Maximum means the maximum benefit payable per Insured Person in a lifetime.

Eligible Expenses are charges for covered services to the extent that they are:

1. not in excess of the Reasonable and Customary charge for the treatment, service or supply and:

   a. Medically Necessary for the diagnosis or treatment of an Illness or Injury; or
   b. covered preventive care; and

2. covered by this rider.

Covered Services are:

1. Hospital outpatient services including surgical services and supplies provided by an Ambulatory Surgical Center or Hospital Outpatient Facility.

2. Services by Physicians, Providers, or Other Healthcare Practitioners for diagnosis or treatment of an Illness or Injury in an outpatient clinic or office.

3. 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.

4. Emergency Care services including:

   a. outpatient Hospital services;
   b. professional ground or air ambulance services for transportation to nearest Hospital equipped to treat the Illness or Injury;
   c. Physician services for an operation, or the repair of a dislocation or fracture; including the services of an assisting surgeon;
   d. anesthesia and its administration; and
   e. services for medical care provided by a Physician, Provider or Other Health Care Practitioner (if not included in c.).

5. 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.

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

7. Home health care services established under a plan of care, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending 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. medical social service;
    d. intravenous therapy;
    e. dialysis;
    f. service provided by unlicensed personnel under the delegation of a licensed health professional;
    g. the furnishing of medical equipment and medical supplies other than drugs and medicine; and
    h. nutritional counseling.

The comprehensive limitations listed in the Policy will apply to home health care services. In addition, comprehensive Covered Charges will not include charges for:

    a. services or supplies not included in the home health care plan;
    b. services of any person who normally lives in your home or your dependent's home;
    c. custodial care (services or supplies provided to assist a person in daily living...e.g., meals and personal grooming); or
    d. transportation services.

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.

We may waive the Policy Year limit on home health services 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 shown in the Schedule of Benefits.

8. Mental health services (including Serious Mental Illness) for:

   a. outpatient evaluation;
   b. crisis intervention; and
   c. services for treatment.

   Benefits will be limited to outpatient services limited to 40 visits per Policy Year.

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

10. Well child care including but not limited to:

   a. ophthalmologic examination for infants at risk for eye problems;

   b. child health supervision services 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;

      covered child health supervision services include:
      1. history;
      2. physical examination;
      3. developmental assessment;
      4. anticipatory guidance;
      5. appropriate Childhood Immunizations;
      6. laboratory testing;
      7. hearing and vision screening.

   Charges for Childhood Immunizations will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived. Remaining covered well child care services will be payable as shown in the Schedule of Benefits.

   In addition, Covered Services will include annual vision and hearing testing for any covered Child under the age of 19. Eligible

Expenses will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived.

11. One annual physical examination. Services include:

    a. history;
    b. physical examination;
    c. 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 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 and Copayment will be waived.]

EXCLUSIONS:

To the extent there is not a conflict, the Exclusions & Limitations of the Policy apply to this rider. In addition to the Exclusions & Limitations of the Policy, the following Exclusion & Limitation applies:

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.

STANDARD HEALTH BENEFIT PLAN

Figure 39

SCHEDULE OF BENEFITS
STANDARD HEALTH BENEFIT PLAN
(Non-PPO Plan)

Policy Year Deductible	[$250] [$500]
Policy Year Copayment Maximum	[$2000] [$5000] per individual [$6000] [$15,000] per family
Policy Year Maximum Benefit	$250,000 (per individual)
Lifetime Maximum Benefit	$1,000,000 (per individual)

COVERED SERVICES	PERCENTAGE PAYABLE
Inpatient and Outpatient Hospitals Subject to Policy Year Deductible	80%
Skilled Nursing Benefit Subject to Policy Year Deductible and Policy Year Maximum of $10,000	80%
Hospice Benefit Subject to Policy Year Deductible and Lifetime Maximum amount of $10,000	80%
Maternity Benefit Subject to Policy Year Deductible	80%
Outpatient Expense Benefit Subject to Policy Year Deductible (includes outpatient clinic or office visits for treatment of an Illness or Injury)	80%

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Mental Health Services Benefit Subject to Policy Year Deductible	80%
Inpatient Hospital Expense	Maximum of 90 days per Policy Year*
Residential Treatment Center or Crisis Stabilization Unit or Psychiatric Day Treatment Facility	Maximum of 180 days per Policy Year**
Outpatient Expense	Maximum of 40 visits per Policy Year and $100 per visit
Chemical Dependency Benefits*** (same as any other Illness)	80%
Subject to Policy Year Deductible	
[Limited to a Lifetime Maximum of three separate series of treatment for each Insured Person.]	
Serious Mental Illness Benefit (same as any other Illness)	80%
Subject to Policy Year Deductible	
Diagnostic Exams, Labs and X-rays Subject to Policy Year Deductible	80%
Preventive Care Benefit Policy Year Deductible and Copayment waived. Includes Childhood Immunizations, pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/hearing testing for children under age of 19.	100%

* Subject to reduction for days treatment is received in Residential Treatment Center, Crisis Stabilization Unit or Psychiatric Day Treatment Facility

** Subject to reduction for days treatment is received under the Inpatient Hospital Expense Benefit

*** Unless waiver attached

Well Child Care Benefit (except for Childhood Immunizations) Subject to Policy Year Deductible	80%
Annual Physical Examination Benefit Subject to Policy Year Deductible (except for services covered under the Preventive Care Benefit)	80%
Therapy Benefit Subject to Policy Year Deductible and limited to Maximum of $10,000 per Policy Year for physical, occupational and speech therapy	80%
Home Health Benefit Subject to Policy Year Deductible and limited to $10,000 per Policy Year	80%

[Prescription Drug Benefit Subject to Policy Year Deductible]	[50%]

or

[Prescription Drug Card Program
Plan pays 100% after the Deductible

Deductible

Generic drug --	[$8] per prescription or refill
Name Brand Drug --	[$12] per prescription or refill]

[Additional benefits added by riders]

Figure 40

SCHEDULE OF BENEFITS
STANDARD HEALTH BENEFIT PLAN
(PPO PLAN)

[Policy Year Deductible or Non-Preferred Provider Policy Year Deductible]	[$250] [$500]
[Preferred Provider Policy Year Deductible]	[ ]
[Per Visit Deductible]	[$ 10] [$ 15]
Policy Year Copayment Maximum	[$2,000] [$5,000] per individual [$6,000] [$15,000] per family [Preferred Provider and Non-Preferred Provider Combined]
Policy Year Maximum Benefit	$ 250,000 (per individual)
Lifetime Maximum Benefit	$1,000,000 (per individual)

COVERED SERVICES	PERCENTAGE PAYABLE PPO	PERCENTAGE PAYABLE NON-PPO
Inpatient and Outpatient Hospitals	[100%] [90%]	[80%] [70%]
	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]
Skilled Nursing Benefit	[100%] [90%]	[80%] [70%]
Subject to Policy Year Maximum of $10,000	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Deductible Waived	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible Waived]

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Hospice Benefit	[100%] [90%]	[80%] [70%]
Lifetime Maximum amount of $10,000	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Deductible Waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible Waived]
Maternity Benefit	[100%][90%]	[80%] [70%]
	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]
Outpatient Expense Benefit (includes outpatient clinic or office visits for treatment of an Illness or Injury)	[100%] [90%]	[80%] [70%]
	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]
Mental Health Services Benefit	[100%] [90%]	[80%] [70%]
	[Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]

	PPO	NON-PPO
Inpatient Hospital Expense	maximum of 90 days per Policy Year *	maximum of 90 days per Policy Year
Residential Treatment Center or Crisis Stabilization Unit or Psychiatric Day Treatment Facility	maximum of 180 days per Policy Year **	maximum of 180 days per Policy Year
Outpatient Expense	maximum of 40 visits per Policy Year and $100 per visit	maximum of 40 visits per Policy Year and $100 per visit
Chemical Dependency Benefits *** (same as any other Illness) [Limited to Lifetime Maximum of three separate series of treatment for each Insured Person.]	100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[80 %] [70%] [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]
Serious Mental Illness Benefit (same as any other Illness)	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[80] [70%] [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]
Diagnostic Exams, Labs and X-rays	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Deductible Waived]	[80%] [70%] [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible Waived]

* Subject to reduction for days treatment is received in Residential Treatment Center, Crisis Stabilization Unit or Psychiatric Day Treatment Facility

** Subject to reduction for days treatment is received under the Mental Inpatient Hospital Expense Benefits

*** Unless waiver attached

	PPO	NON-PPO
Preventive Care Benefit Policy Year Deductible and Copayment waived. (Includes Childhood Immunizations pap tests, Low-Dose Mammography for female insureds age 35 and over, colo-rectal screening, prostate cancer screening, and vision/ hearing testing for children under age of 19.	100% No Deductible	100% No Deductible
Well Child Care Benefit (except for Childhood Immunizations)	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[80%] [70% [Subject to Policy Year Deductible or [Subject to Non-Preferred Provide Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]
Annual Physical Examination Benefit (except for services covered under the Preventive Care Benefit)	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[80%] [70%] [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider] or [Subject to Per Visit Deductible] or [Deductible Waived]
Therapy Benefit Limited to Maximum of $10,000 per Policy Year for physical, occupational and speech therapy	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]	[80%] [70%] [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Subject to Per Visit Deductible] or [Deductible Waived]

	PPO	NON-PPO
Home Health Benefit Limited to $10,000 per Policy Year	[100%] [90%] [Subject to Policy Year Deductible] or [Subject to Preferred Provider Deductible] or [Deductible Waived]	[80%] [70%] [Subject to Policy Year Deductible] or [Subject to Non-Preferred Provider Deductible] or [Deductible Waived]

[PRESCRIPTION DRUG CARD PROGRAM
Plan pays 100% after Deductible

Deductible
Generic drug - [$ 8] per prescription or refill
Name Brand - [$12] per prescription or refill]

or

[PRESCRIPTION DRUG BENEFIT
Percentage Payable [50%]
Subject to the Policy Year Deductible]

[Schedule for Covered Services added by riders]

Figure 41

POLICY DEFINITIONS
STANDARD BENEFIT PLAN

Affiliated Employer means a person connected by commonality of 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 and discharged from within a twenty-four (24) hour period.

Beneficiary means the person you designate to receive any unassigned benefits that are paid after your death.

[Certificate of Insurance means the individual certificate issued to the Insured Person which describes the coverage provided by the Policy.]

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

Chemical Dependency Treatment Center means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and which 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 Hospitals; or
3. licensed as a chemical dependency treatment program by the Texas Commission on Alcohol or 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.

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Child means the unmarried:

1. natural Child of the Insured Person including a newborn Child;
2. adopted Child including a Child who the Insured Person is seeking to adopt;
3. natural Child or adopted Child of the Insured Person's spouse provided the Child resides with the Insured Person.

Childhood Immunizations means a test for tuberculosis, immunization and re-immunization against diphtheria, tetanus, poliomyelitis, *Haemophilus influenzae type b,* measles, mumps, rubella, and hepatitis B.

Complication of Pregnancy mean:

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

[For Chapter 20 companies only:
Contracting Facility means a Hospital, a Facility Other Provider or any other facility that We have a written contract with to provide care, services or supplies that are covered by the Policy. A Contracting Facility also means a Hospital or Facility Other Provider located outside of Texas, that another insurance company has a contract with that allows us to use its facilities.

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

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

Dependent means:

1. a spouse;
2. a newborn Child;
3. a Child under the age of 19 years;
4. a Child who is a full-time student under the age of 23 years and who is financially dependent upon the parent;
5. a Child of any age who is medically certified as disabled and dependent on the parent;
6. an adopted Child,
7. a grandchild who is your dependent for federal income tax purposes

Educational means that the primary purpose of the service or supply is to provide the Insured Person with any of the following:

1. training in the activities of daily living;
2. instruction in scholastic skills such as reading and writing;
3. preparation for an occupation;
4. or treatment for learning disabilities.

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

Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by 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.

Employee means you, the principal insured, hereafter referred to as "you".

Employer means an individual, corporation, partnership, association, or other private legal entity 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 whom were employed in this state. **[Employer** includes Employer Members of an Association that meets the criteria defined above.]

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 definition of Medically Necessary to resolve a dispute regarding Experimental treatment.

Generic means drugs not protected by a trademark registration.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a group hospital service contract, or a group subscriber contract or evidence of coverage issued by a health maintenance organization that provides benefits for health care services. The term does not include:

1. accident-only, credit or disability insurance coverages;
2. specified disease coverage or other limited benefit policies;
3. coverage of Medicare services under a federal contract;
4. Medicare Supplement and Medicare Select policies regulated in accordance with federal law;
5. long-term care, dental care, or vision care coverages;
6. coverage provide by a single service health maintenance organization;
7. insurance coverage issued as a supplement to liability insurance;
8. insurance coverage arising out of a workers' compensation system or similar statutory system;
9. automobile medical payment insurance coverage;
10. jointly managed trusts authorized under 29 U.S.C. Section 141 et seq. that contain a plan of benefits for employees that is negotiated in a collective bargaining agreement governing wages, hours, and working conditions of the employees that is authorized under 29 U.S.C. Section 157;
11. hospital confinement indemnity coverage; or
12. reinsurance contracts issued on a stop-loss, quota-share, or similar basis.

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

Hospital means

1. a facility that
   a. is licensed as a Hospital and operated pursuant to law;
   b. is primarily engaged in providing or operating either on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians, medical diagnostic and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made;
   c. provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.);
   d. maintains and operates a minimum of five beds;
   e. has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis;
   f. maintains permanent medical history records; or
2. a facility that
   a. is accredited by the Joint Commission on Accreditation of Healthcare Organization; and
   b. offers medical therapeutic, and psychiatric care for the treatment of Chemical Dependency.

The major surgery facility requirement is hereby waived for facilities that specialize in treating the mentally ill.

Hospital does not mean convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital.

Illness means sickness, disease, pregnancy or Complications of Pregnancy that are first manifested after the Effective Date of insurance and while the Policy is in force.

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

Insured Person means you and/or your Dependents, if insured under the Policy.

Low-Dose Mammography means the X-ray examination of the breast using equipment dedicated specifically for mammography including the X-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid breast, with two views for each breast.

Medically Necessary means 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 may appeal any decision We make to deny your claim or any part of your claim. Our written notice of denial will include the reasons for the denial, including any documentation that We used in making our decision.

You or your Physician, Provider or Other Healthcare Practitioner or another person acting on your behalf may submit additional information to Us and request reconsideration of the claim.

If We have not given you an answer within 15 days or we again deny your claim or any part of your claim, you may 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 mediation or arbitration, and We will pay the remainder of the cost.

Name Brand means a drug protected by trademark registration.

[For Chapter 20 companies only:
Noncontracting Facility means a Hospital, a Facility Other Provider or any other facility that We do not have a written contact with.]

Physician means a duly licensed Doctor of Medicine (MD.) or Doctor of Osteopathy (DO.) who is practicing within the scope of his or her license.

[Policy Year means a 365 day period that begins on the anniversary of the Policy's Effective Date.]
[Policy Year means a period of one full calendar year.]

[Policyholder:
[Policyholder means the Employer.]
[Policyholder means the Association.]
[Policyholder means the Trustee of a Multiple Employer Trust.]

[Preexisting Condition means 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.

In addition, a Preexisting Condition will include any pregnancy existing on the Effective Date.]

Provider or Other Health Care Practitioner a duly licensed or certified practitioner of the healing arts including, but not limited to, a Physician's assistant or an advanced nurse practitioner, who is acting within the scope of said license or certificate.

Psychiatric Day Treatment Facility means a mental health facility that 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.

Reasonable and Customary means 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; and
2. whose Illness or Injury is comparable in nature and severity.

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

You may use the appeals process under the definition of Medically Necessary to resolve a dispute regarding Reasonable and Customary charges.

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.

Schedule of Benefits means the benefit schedule set forth in the Policy or Certificate.

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).

Skilled Nursing Facility means a facility that is operated pursuant to law and is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed Physician. It must provide continuous, 24-hours-a-day nursing service by or under the supervision of a registered graduate professional nurse (RN.); and maintain a daily medical record of each patient. A Skilled Nursing Facility is not, except by incident, a rest home, a home for the care if the aged, or engaged in the care and treatment of chemical or alcohol dependence.

Figure 42

BENEFITS PROVIDED
STANDARD HEALTH BENEFIT PLAN

If you or your Dependent incur expense for Covered Services while covered under the Policy, We will pay a percentage of that Eligible Expense after the Deductible is satisfied. We will pay up to the Maximums for each Insured Person. The Percentage Payable, Deductible, and Maximums are shown in the Schedule of Benefits.

Deductible means the amount of Eligible Expenses shown in the Schedule of Benefits for each Insured Person for which We will pay no benefits during each Policy Year.

Copayment means, after the Deductible has been met, the amount you must pay for Eligible Expenses under the Policy. Copayment does not include any services or charges which are not covered under the Policy, the Deductible or Covered Services under any attached rider.

The **Individual Policy Year Copayment Maximum** for an Insured Person is [$2,000] [$5,000]. After the Copayments for an Insured Person equal [$2,000] [$5,000] in one Policy Year, the Percentage Payable will increase to 100% for the remainder of that Policy Year.

The **Family Policy Year Copayment Maximum** for Insured Persons within one family is [$6,000] [$15,000]. If Copayments for you and your Dependents equal [$6,000] [$15,000] in one Policy Year, the Percentage Payable for those Insured Persons within that family will increase to 100% for the remainder of the Policy Year. No Insured Person will be required to satisfy more than the Individual Policy Year Copayment Maximum.

Policy Year Maximum means the maximum benefit payable per Insured Person in a Policy Year.

Lifetime Maximum means the maximum benefit payable per Insured Person's lifetime.

Eligible Expenses are charges for Covered Services to the extent that they are:

1. not in excess of the Reasonable and Customary charge for the treatment, service or supply, and

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a. Medically Necessary for the diagnosis or treatment of an Illness or Injury; or
b. covered preventive care services; and

2. covered by the Policy.

Covered Services and Supplies are:

1. services by Physicians, Providers or Other Health Care Practitioners for diagnosis, treatment, and surgery of an Illness or Injury.

2. daily Hospital room, board and general nursing services equal to the average semi-private room rate. Charges made by a Hospital for a private room will be considered an Eligible Expense in the amount not greater than the average semi-private room rate.

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

4. 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.

5. anesthesia and its administration.

6. assistant surgery fee (not to exceed 25% of the primary surgeon's fee for any one assistant) when the procedure requires an assistant surgeon(s) due to medical necessity.

7. professional ground or air ambulance services for transportation to the nearest Hospital equipped to treat the Injury or Illness as needed for Emergency Care. You can use the appeals process under the definition of Medically Necessary to resolve a dispute regarding Emergency Care.

8. outpatient services made by a Hospital or other emergency care facility for Emergency Care. You can use the appeals process under the definition of Medically Necessary to resolve a dispute regarding Emergency Care.

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

10. oxygen and the rental of equipment for its administration.

11. rental or purchase, at out 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.

12. inpatient and outpatient radiation therapy, inhalation therapy, and chemotherapy.

13. inpatient and outpatient X-ray and laboratory services, including imaging services, pathology, radiology, and the interpretation thereof.

14. 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.]

15. 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.

16. Well child care including but not limited to:

    a. Ophthalmologic examination for infants at risk for eye problems;
    b. Charges for child health supervision services 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;
    c. Covered child health supervision services include:

        1. history;
        2. physical examination;
        3. developmental assessment;
        4. anticipatory guidance;
        5. appropriate childhood immunizations;
        6. laboratory testing;
        7. hearing and vision screening.

    Charges for Childhood Immunizations will be payable at 100% of the Reasonable and Customary charges and the Deductible and

Copayment will be waived. Remaining covered well child care expenses will be payable as shown in the Schedule of Benefits.

In addition, Covered Services will include annual vision and hearing testing for any covered child under the age of 19. Charges will be payable at 100% of the Reasonable and Customary charges. The Deductible and Copayment will be waived.

17. one annual physical examination. Services include:

    a. history;
    b. physical examination;
    c. laboratory and x-rays including pap tests, colo-rectal screening, and prostate cancer screening.

    Charges 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 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 Low-dose Mammography for any female insured age 35 and over. Charges will be payable at 100% of the Reasonable and Customary charges and the Deductible and Copayment will be waived.

18. 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.

19. 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.

20. room, board, and other services in a Skilled Nursing Facility provided the confinement is certified by a Physician as necessary for recovery from an Illness or Injury and in lieu of Hospital confinement. Covered charges are subject to a maximum benefit of $10,000 per Policy Year.

21. hospice care provided by a licensed Hospice Care Facility for any Insured Person who, in the opinion of the attending Physician, has no reasonable prospect of cure and is expected to live no longer

than six months. Covered charges are subject to a Maximum Lifetime benefit of $10,000.

22. inpatient and outpatient mental health services. Covered expenses include:

    a. Inpatient mental health services, limited to a maximum of 90 days per Policy Year.
    b. 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.
    c. Treatment in a Crisis Stabilization Unit or a Residential Treatment Center for Children and Adolescents. Benefits are payable only if an Insured Person has a mental illness which 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.
    d. 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.

23. treatment of Serious Mental Illness, including inpatient and outpatient evaluation, crisis intervention and services for treatment. These services are 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 21(b) and (c), but will not be limited by number of days.

24. home health services under a plan of care established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending 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. medical social service;
d. intravenous therapy;
e. dialysis;
f. service provided by unlicensed personnel under the delegation of a licensed health professional;
g. the furnishing of medical equipment and medical supplies other than drugs and medicine; and
h. nutritional counseling.

The comprehensive limitations listed in the Policy will apply to home health care services. In addition, comprehensive covered charges will not include charges for:

a. services or supplies not included in the home health care plan;
b. services of any person who normally lives in your home or is a member of the Insured Person's Immediate Family (you, your spouse, your parent, brother or sister);
c. custodial care (services or supplies provided to assist a person in daily living...e.g., meals and personal grooming) or
d. transportation services.

Covered charges are subject to a maximum limit of $10,000 per Policy Year.

We may waive the Policy Year limit on home health services 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 shown in the Schedule of Benefits.

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 plan:

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.

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: This benefit is subject to the following exclusions which are in addition to the exclusions stated under the Exclusions and Limitations provision unless otherwise indicated. 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.

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 & 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 prescribed for an Injury or Illness arising out of employment.

17. 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.

1993 Publication Schedule for the *Texas Register*

Listed below are the deadline dates for the January-December 1993 issues of the *Texas Register*. Because of printing schedules, material r after the deadline for an issue cannot be published until the next issue. Generally, deadlines for a Tuesday edition of the *Texas R* Wednesday and Thursday of the week preceding publication, and deadlines for a Friday edition are Monday and Tuesday of the v publication. No issues will be published on July 30, November 5, November 30, and December 28. A asterisk beside a publication date i that the deadlines have been moved because of state holidays.

FOR ISSUE PUBLISHED ON	ALL COPY EXCEPT NOTICES OF OPEN MEETINGS BY 10 A.M.	ALL NOTICES OF OPEN MEETINGS BY 10 A.M.
34 Tuesday, May 4	Wednesday, April 28	Thursday, April 29
35 Friday, May 7	Monday, May 3	Tuesday, May 4
36 Tuesday, May 11	Wednesday, May 5	Thursday, May 6
37 Friday, May 14	Monday, May 10	Tuesday, May 11
38 Tuesday, May 18	Wednesday, May 12	Thursday, May 13
39 Friday, May 21	Monday, May 17	Tuesday, May 18
40 Tuesday, May 25	Wednesday, May 19	Thursday, May 20
41 Friday, May 28	Monday, May 24	Tuesday, May 25
42 Tuesday, June 1	Wednesday, May 26	Thursday, May 27
43 *Friday, June 4	Friday, May 28	Tuesday, June 1
44 Tuesday, June 8	Wednesday, June 2	Thursday, June 3
45 Friday, June 11	Monday, June 7	Tuesday, June 8
46 Tuesday, June 15	Wednesday, June 9	Thursday, June 10
47 Friday, June 18	Monday, June 14	Tuesday, June 15
48 Tuesday, June 22	Wednesday, June 16	Thursday, June 17
49 Friday, June 25	Monday, June 21	Tuesday, June 22
50 Tuesday, June 29	Wednesday, June 23	Thursday, June 24
51 Friday, July 2	Monday, June 28	Tuesday, June 29
52 Tuesday, July 6	Wednesday, June 30	Thursday, July 1
53 Friday, July 9	Monday, July 5	Tuesday, July 6
Tuesday, July 13	SECOND QUARTERLY INDEX	
54 Friday, July 16	Monday, July 12	Tuesday, July 13
55 Tuesday, July 20	Wednesday, July 14	Thursday, July 15
56 Friday, July 23	Monday, July 19	Tuesday, July 20
57 Tuesday, July 27	Wednesday, July 21	Thursday, July 22
Friday, July 30	NO ISSUE PUBLISHED	
58 Tuesday, August 3	Wednesday, July 28	Thursday, July 29
59 Friday, August 6	Monday, August 2	Tuesday, August 3
60 Tuesday, August 10	Wednesday, August 4	Thursday, August 5
61 Friday, August 13	Monday, August 9	Tuesday, August 10
62 Tuesday, August 17	Wednesday, August 11	Thursday, August 12
63 Friday, August 20	Monday, August 16	Tuesday, August 17
64 Tuesday, August 24	Wednesday, August 18	Thursday, August 19

65 Friday, August 27	Monday, August 23	Tuesday, August 24
66 Tuesday, August 31	Wednesday, August 25	Thursday, August 26
67 Friday, September 3	Monday, August 30	Tuesday, August 31
68 Tuesday, September 7	Wednesday, September 1	Thursday, September 2
69 *Friday, September 10	Friday, September 3	Tuesday, September 7
70 Tuesday, September 14	Wednesday, September 8	Thursday, September 9
71 Friday, September 17	Monday, September 13	Tuesday, September 14
72 Tuesday, September 21	Wednesday, September 15	Thursday, September 16
73 Friday, September 24	Monday, September 20	Tuesday, September 21
74 Tuesday, September 28	Wednesday, September 22	Thursday, September 23
75 Friday, October 1	Monday, September 27	Tuesday, September 28
76 Tuesday, October 5	Wednesday, September 29	Thursday, September 30
77 Friday, October 8	Monday, October 4	Tuesday, October 5
Tuesday, October 12	THIRD QUARTERLY INDEX	
78 Friday, October 15	Monday, October 11	Tuesday, October 12
79 Tuesday, October 19	Wednesday, October 13	Thursday, October 14
80 Friday, October 22	Monday, October 18	Tuesday, October 19
81 Tuesday, October 26	Wednesday, October 20	Thursday, October 21
82 Friday, October 29	Monday, October 25	Tuesday, October 26
83 Tuesday, November 2	Wednesday, October 27	Thursday, October 28
Friday, November 5	NO ISSUE PUBLISHED	
84 Tuesday, November 9	Wednesday, November 3	Thursday, November 4
85 Friday, November 12	Monday, November 6	Tuesday, November 9
86 Tuesday, November 16	Wednesday, November 10	Thursday, November 11
87 Friday, November 19	Monday, November 15	Tuesday, November 16
88 Tuesday, November 23	Wednesday, Novmber 17	Thursday, November 18
89 Friday, November 26	Monday, November 22	Tuesday, November 23
Tuesday, November 30	NO ISSUE PUBLISHED	
90 Friday, December 3	Monday, November 29	Tuesday, November 30
91 Tuesday, December 7	Wednesday, December 1	Thursday, December 2
92 Friday, December 10	Monday, December 6	Tuesday, December 7
93 Tuesday, December 14	Wednesday, December 8	Thursday, December 9
94 Friday, December 17	Monday, December 13	Tuesday, December 14
95 Tuesday, December 21	Wednesday, December 15	Thursday, December 16
96 Friday, December 24	Monday, December 20	Tuesday, December 21
Tuesday, December 28	NO ISSUE PUBLISHED	

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