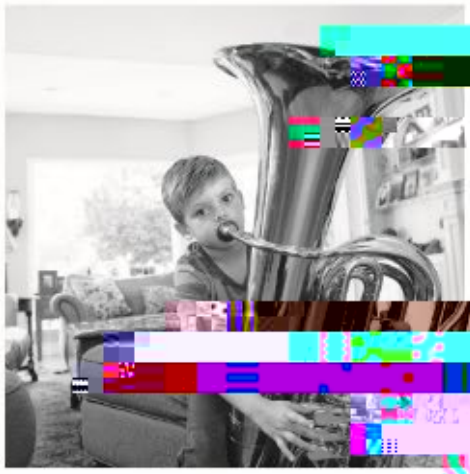
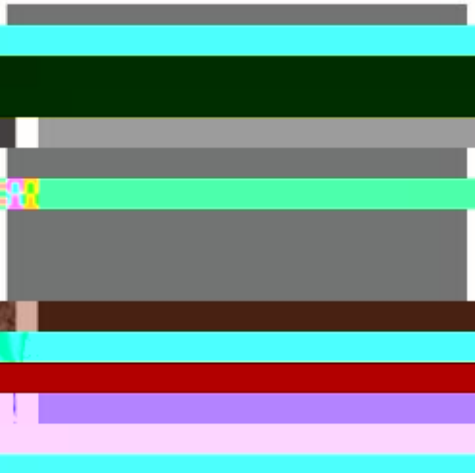
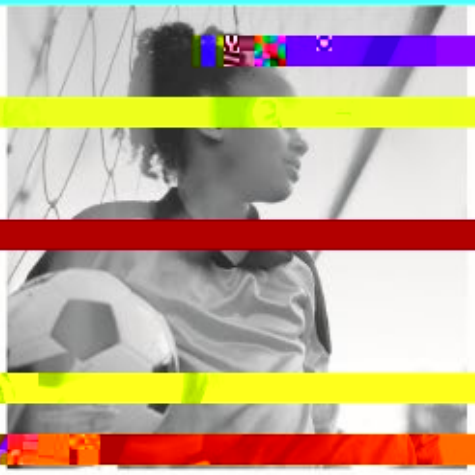
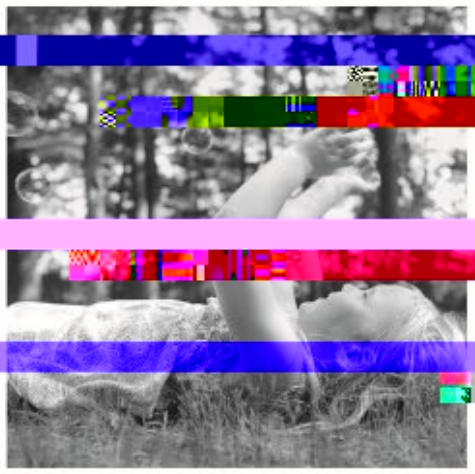
ministered by:

BlueCross BlueShield of Texas









Your

SCHEDULE OF COVERAGE

Plan Provisions	In-

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SCHEDULE OF COVERAGE

Plan Provisions	Blue Distinction
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INTRODUCTION

This Plan is offered by your Employer as one of the benefits of your employment. The benefits provided are intended to assist you with many of your health care expenses for Medically Necessary services and supplies. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity or sexual orientation. There are provisions throughout this Benefit Booklet that affect your health care coverage. It is important that you read the Benefit Booklet carefully so you will be aware of the benefits and requirements of this Plan.

The defined terms in this Benefit Booklet are capitalized and shown in the appropriate provision in the Benefit Booklet or in the DEFINITIONS section of the Benefit Booklet. Whenever these terms are used, the meaning is consistent with the definition given. Terms in italics may be section headings describing provisions or they may be defined terms.

The terms “you” and “your” as used in this Benefit Booklet refer to the Employee.

Managed Health Care - In-Network Benefits

To receive In-Network Benefits as indicated on your Schedule of Coverage, you must choose Providers within the Network for all care (other than for emergencies). The Network has been established by BCBSTX and consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Participants throughout the Network Plan Service Area. Refer to your Provider directory or visit the BCBSTX website at www.bcbstx.com to make your selections. The listing may change occasionally, so make sure the Providers you select are still Network Providers. An updated directory will be available at least annually. You may access our website, www.bcbstx.com, for the most current listing to assist you in locating a Provider.

If you choose a Network Provider, the Provider will bill the Claim Administrator - not you - for services provided.

The Provider has agreed to accept as payment in full the lesser of:

- The billed charges, or
- The Allowable Amount as determined by the Claim Administrator, or
- Other contractually determined payment amounts.

You are responsible for paying any Deductibles, Copayment Amounts, and Co-Share Amounts. The Deductibles and Co-Share will be applied to the Out-of-Pocket Maximum. You may be required to pay for limited or non-covered services. No claim forms are required.

Managed Health Care - Out-of-Network Benefits

If you choose Out-of-Network Providers, only Out-of-Network Benefits will be available. If you go to a Provider outside the Network, benefits will be paid at the Out-of-Network Benefits level. If you choose a health care Provider outside the Network, you may have to submit claims for the services provided.

You will be responsible for paying:

- Billed charges above the Allowable Amount as determined by the Claim Administrator,
- Co-Share Amounts and Deductibles, which will be applied to the Out-of-Pocket Maximum,
- Limited or non-covered services, and
- Failure to obtain Prior Authorization penalty.

Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	1-888-762-2190	Monday – Friday 8:00 a.m. – 8:00 p.m.
Website	www.bcbstx.com	24 hours a day 7 days a week
Medical Prior Authorization Helpline	1-800-441-9188	Monday – Friday 6:00 a.m. – 6:00 p.m.
Mental Health/Substance Use Disorder Prior Authorization Helpline	1-800-528-7264	24 hours a day 7 days a week

Customer Service Helpline

Customer Service Representatives can:

- Identify your Plan Service Area
- Give you information about Network and Par Plan Providers
- Distribute claim forms
- Answer your questions on claims
- Assist you in identifying a Network Provider (but will not recommend specific Network Providers)
- Provide information on the features of the Plan
- Record comments about Providers

Benefits Value Advisor (BVA)

The Benefit Value Advisor (BVA) program has been established to assist Participants in maximizing their benefits under the Plan. Benefit Value Advisors are specially-trained customer service representatives who assist Participants by comparing cost and providing information on Participating Providers for certain types of health care services. A BVA helps Participants navigate their benefits.

In addition to calling the Benefit Value Advisors, Participants may have other call requirements. A call to BVA does not satisfy any other call requirements Participants may have.

BCBSTX Website

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WHO GETS BENEFITS

Eligibility Requirements for Coverage

Please refer to the CARES Health Plan Supplement in the back of the booklet.

- Co-Share Amounts, and
- Services that are limited or not covered under the Plan.

NOTE

Utilization Management

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. Seri M edicale Necse ty

Surgical Procedures:

- Orthognathic surgery; facreconstruction,
- Mastopexy, breastlift,
- Reduction mammoplasty; breast reduction,

Specialty Pharmacy:

- Medical Benefit Specialty Drugs (Specuc 8.87u 11 [(Q q 4eyon >>BDC)2.uc 8.8.,eauc 8..3 (t).716r21339 0 T

independent review, apply to services where your Provider requests a Recommended Clinical Review.

Recommended Clinical Review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of the Plan. Please coordinate with your Provider to submit a written request for a Recommended Clinical Review.

General Provisions Applicable to All Recommended Clinical Reviews

1. No Guarantee of Payment

   A Recommended Clinical Review is not a guarantee of benefits or payment of benefits by BCBSTX. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved in a Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, you may have become ineligible as of the date of service or the member's benefits may have changed as of the date of service.

2. Request for Additional Information

   The Recommended Clinical Review process may require additional documentation from your Provider or pharmacist. In addition to the written request for a Recommended Clinical Review, the Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by BCBSTX to make a determination of coverage pursuant to the terms and conditions of this Plan.

Post-Service Medical Necessity Review

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms your eligibility, availability of benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered.

- You may be responsible for a penalty in connection with the following Covered Services, if indicated on your Schedule of Coverage:
  - Inpatient Hospital Admission
  - Inpatient treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder

Network Providers are responsible for satisfying Prior Authorization requirements for any inpatient admissions. If Prior Authorization is not obtained, the Network Provider will be sanctioned based on the BCBSTX contract agreement with the Provider and no penalty charges will be deducted.

The penalty charge will be deducted from any benefit payment which may be due for Covered Services.

If Prior Authorization of an inpatient Hospital Admission, Extended Care Expense, Home Infusion Therapy, any treatment of Mental Health Care, treatment of Serious Mental Illness, and treatment of Substance Use Disorder or extension for any treatment or service described above is not obtained and it is determined that the treatment, service, or extension was not Medically Necessary or was Experimental/Investigational, benefits will be reduced or denied.

Prior Authorization Renewal Process

Renewal of an existing Prior Authorization issued by BCBSTX can be

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

Except as provided in the section Assignment and Payment of Benefits, rights and benefits under the Plan are not assignable, either before or after services and supplies are provided.

Benefit Payments to a Managing Conservator

Benefits for services provided to your minor Dependent child may be paid to a third party if:

- the third party is named in a court order as managing or possessory conservator of the child; and
- the Claim Administrator has not received written notice of the court order at least 30 days before the date benefits are paid.

If a Claim Is Denied or Not Paid in Full

On occasion, the Claim Administrator may deny all or part

A "Final Internal Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by the Claim Administrator or, if applicable, CARES, at the completion of the internal review/appeal process of an Adverse Benefit Determination Deter8n

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

If you don't appeal on time, you lose your right to later object to the decision on the claim.

Timing of Appeal Determinations. Note: Your Plan provides for one level of internal review

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Deadline by which a claimant will be notified of an appeals decision	As soon as possible taki into account the medic exigencies, but no more than 72 hours after receipt of the request for review. Note: The request may b submitted in writing o orally.	Not later than 30 days aft receipt of the request f review. (Not later than 1 days for each level if you Plan offers two levels o Internal review.)	Not later than 60 days after receipt of the request for review. (Not later than days for each level if your Plan offe two levels of internal review).

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any healthcare provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice to you or your authorized representative will include:

1. A reason for the determination;
2. A reference to the benefit Plan provisions on which the determination is based, and the contractual,

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

Claim Dispute Resolution

You must exhaust all administrative remedies as described in the Claim Review/Appeal Procedures subsection prior to taking further action under your Health Benefit Plan.

After exhaustion of all remedies offered by the Claim Administrator, your Health Benefit Plan may afford you the right to appeal an adverse determination with the Plan Administrator of your Health Benefit Plan. In that instance, the Plan Administrator is the final interpreter of the Health Benefit Plan and may correct any defect, supply any

Family Out-of-Pocket Maximum

When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the "family" Out-of-Pocket Maximum" shown on your Schedule of Coverage for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

The following are exceptions to the Out-of-Pocket Maximum described above:

There are separate Out-of-Pocket Maximums for In-Network Benefits and Out-of-Network Benefits.

Eligible Expenses applied toward satisfying the "individual" and "family" In-Network Out-of-Pocket Maximum will only apply to the In-Network Out-of-Pocket Maximum. Eligible Expenses applied toward satisfying the "individual" and "family" Out-of-Network Out-of-Pocket Maximum will only apply to the Out-of-Network Out-of-Pocket Maximum.

Changes In Benefits

Changes to covered benefits will apply to all services provided to each Participant under the Plan. Benefits for Eligible Expenses incurred during an admission in a Hospital or Facility Other Provider that begins before the change will be those benefits in effect on the day of admission.

confined to bed and cannot be safely transported by any other means. Non-emergency ground ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.

Non-emergency air ambulance transportation means transportation from a Hospital emergency department, health care facility, or Inpatient setting to an equivalent or higher level of acuity facility may be considered Medically Necessary when the Participant requires acute Inpatient care and services are not available at the originating facility and commercial air transport or safe discharge cannot occur. Non-emergency air ambulance transportation services provided primarily for the convenience of the Participant, the Participant's family/caregivers or Physician, or the transferring facility are considered not Medically Necessary.

8. Anesthetics and its administration, when performed by someone other than the operating Physician or Professional Other Provider.
9. Oxygen and its administration provided the oxygen is actually used.
10. Blood, including cost of blood, blood plasma, and blood plasma expanders which is not replaced by or for the Participant.
11. Prosthetic Appliances, including replacements necessitated by growth to maturity of the Participant.
12. Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces and

the benefit maximums under both levels of benefits.

The benefit maximums will also include any benefits provided to a Participant for Extended Care Expenses under a Health Benefit Plan held by the Employer with the Claim Administrator immediately prior to the Participant's Effective Date of coverage under the Plan.

The Calendar Year Deductible will apply. Any unpaid Extended Care Expenses in excess of the benefit maximums shown on your Schedule of Coverage will not be applied to any Out-of-Pocket Maximum.

Any charges incurred as Home Health Care or home Hospice Care for drugs (including antibiotic therapy) and laboratory services will not be Extended Care Expenses but will be considered Medical Surgical Expenses.

Services and supplies for Extended Care Expenses:

1. For Skilled Nursing Facility:
   a. All usual nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.), or by a Licensed
   b. Room and board and all routine services, supplies, and equipment provided by the Skilled Nursing Facility.
   c. Physical, occupational, speech, and respiratory therapy services by licensed therapists.
2. For Home Health Care:
   a. Part-time or intermittent nursing care by a Registered Nurse (R.N.), Advanced Practice Nurse (A.P.N.),

Benefits for Treatment of Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness. Dependent children will be eligible for treatment of Complications of Pregnancy.

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other

All treatment received following the onset of an accidental injury or emergency care will be eligible for In-Network Benefits. For a non-emergency, In-Network Benefits will be available only if you use Network Providers. For a non-emergency, if you can safely be transferred to the care of a Network Provider but are treated by a non-Network Provider, only Out-of-Network Benefits will be available.

Benefits for Urgent Care

Benefits for Eligible Expenses for Urgent Care will be determined as shown on your Schedule of Coverage. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a hospital emergency room/treatment room or physician's office. The necessary medical care is for a condition that is not life-threatening.

Benefits for Retail Health Clinics

Benefits for Eligible Expenses for Retail Health Clinics will be determined as shown on your Schedule of Coverage. Retail Clinics provide diagnosis and treatment of uncomplicated minor conditions in situations that can be handled without a traditional primary care office visit, Urgent Care visit or Emergency Care.

Benefits for Virtual Visits

Benefits for Eligible Expenses for Virtual Visits will be determined as shown on your Schedule of Coverage. BCBSTX provides you with access to Virtual Providers that can provide diagnosis and treatment of non-emergency medical and behavioral health conditions in situations that can be handled without a traditional primary care office visit, behavioral health office visit, Urgent Care visit or Emergency Care visit. Covered Services may be provided via consultation with a licensed medical professional through interactive audio via telephone or interactive audio-video via online portal or mobile application. For information on accessing this service, you may access the website at www.bcbstx.com or contact customer service at the toll-free number on the back of your Identification Card.

Note: not all medical or behavioral health conditions can be appropriately treated through Virtual Visits. The Virtual Virt.3 (l)2.

- Services provided to a newborn child which are necessary for treatment or correction of a congenital defect; or
- The correction of damage caused solely by Accidental Injury, and such injury resulting from domestic violence or a medical condition, to healthy, un-restored natural teeth and supporting tissues. An injury sustained as a result of biting or chewing shall not be considered an Accidental Injury.

Any other dental services, except as excluded in the MEDICAL LIMITATIONS AND EXCLUSIONS section of this Benefit Booklet, for which a Participant incurs Inpatient Hospital Expenses for a Medically Necessary inpatient Hospital Admission, will be determined as described in Benefits for Inpatient Hospital Expenses.

Benefits for Organ and Tissue Transplants

1. Subject to the conditions described below, benefits for covered services and supplies provided to a Participant by a Hospital, Physician, or Other Provider related to an organ or tissue transplant will be

Benefits for Treatment of Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition. Eligible Expenses include the following services as a result of and related to an Acquired Brain Injury:

- Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others;
- Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior;
- Neurophysiological testing – An evaluation of the functions of the nervous system;
- Neurophysiological treatment – Interventions that focus on the functions of the nervous system;
- Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning;
- Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes;
- Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior;
- Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors;
- Remediation –

c. Lancets and lancet devices,
d. Insulin and insulin analog preparations,
e. Injection aids, including devices used to assist with insulin injection and needleless systems,
f. Biohazard disposable containers,
g. Insulin syringes,
h. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
i. Glucagon emergency kits.

3. Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.

4. As new or improved treatment and monitoring equipment or supplies become available and are approved by U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treat 1 Tf 0 Tc 0 Tw 0 Tc 0 2.3 (e)4.4 (r)2.7 (m)ar app s-1.4 (y)

includes, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods a
approved by the United Stat test Food and Drug Administration alone or in combination with a test approved by the
United States Food and Drug Administration for the detection of the h papilloma pa virus.

Benefits for Childhood Immunizations

Benefits for Medical Surgical Expenses incurr

any other sickness. Refer to the UTILIZATION MANAGEM

MEDICAL LIMITATIONS AND EXCLUSIONS

The benefits as described in this Benefit Booklet are not available for:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2.

27. Any services or supplies provided for the following treatment modalities:

    - intersegmental traction;
    - surface EMGs;
    - spinal manipulation under anesthesia; and
    - muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

28. Any services or supplies furnished by a Contracting Facility for which such facility had not been specifically approved to furnish under a written contract or agreement with the Claim Administrator will be paid at the Out-of-Network benefit level.

29. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-hospital setting or purchased "over-the-counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, made or built-up shoes; casts; shoes; shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports; fractures [illegible]

- post-acute transition services. Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration; and
- community reintegration services. Services that facilitate the continuum of care as an affected individual transitions into the community.

41. Biofeedback or other behavior modification services.

42. Elective abortions.

43. Any related services to a non-covered service. Related services are:

- services in preparation for the non-covered service;
- services in connection with providing the non-covered service;
- hospitalization required to perform the non-covered service; or
- services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.

44. Any services or supplies from more than one Provider on the same day(s) to the extent benefits were duplicated.

45. Behavioral health services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses and group homes, except for Covered Services provided by appropriate Providers as listed in this Benefit Booklet.

46. Any of the following applied behavior analysis (ABA) services;

- services with a primary diagnosis that is not Autism Spectrum Disorder;
- services that are facilitated by a Provider that is not properly credentialed. Please see the definition of Qualified ABA Provider in the DEFINITIONS section of this Benefit Booklet;
- activities primarily of an educational nature;
- respite, shadow, or companion services; or
- any other services not provided by an appropriately licensed Provider in accordance with nationally accepted treatment standards.

47. Any services or supplies not specifically defined as Eligible Expenses in this Plan.

48. Elective Sterilization.

DEFINITIONS

The definitions used in this Benefit Booklet apply to all coverage unless otherwise indicated.

Accidental Injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a Physician or Professional Other Provider.

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

Allowable Amount means the maximum amount determined by the Claim Administrator (BCBSTX) to be eligible for consideration of payme

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Dietary and Nutritional Services means the education, counseling, or training of a Participant (including printed material)

The Claim Administrator for the Plan shall determine whether a treatment, procedure, facility, equipment, drug, device, or supply is Experimental/Investigational, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination.

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

Extended Care Expenses means the Allowable Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in the Extended Care Expenses portion of this Benefit Booklet.

Fixed-Wing Air Ambulance means a specially equipped airplane used for ambulance transport.

Group Health Plan (GHP) as applied to this Benefit Booklet means a self-funded employee welfare benefit plan. For additional information, refer to the definition of Plan Administrator.

Health Benefit Plan means a group, blanket, or franchise insurance policy, a certificate issued under a group policy, a new 2.508 cale i16 43 on 14l51c -1,l1 t;235 0 Td (a)Tj Td [(cf -0.0LBody2 Tc 0.00612Tw

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

Morbid Obesity means a Body Mass Index (BMI) of greater than or equal to 40 kg/meter^2 or a BMI greater than or ete00 0 10.98 D]TJ 0.0i4 (i)2.3 (l)2.3 i 10BDC Q q 0 0 612 79-36.[(m)1.1 (ean<i (m y9500 T o .0i4303 Tc 0.1

d. Doctor of Optometry
e. Doctor of Podiatry
f. Doctor in Psychology
g. Licensed Acupuncturist
h. Licensed Audiologist
i.

Plan Month means each succeeding calendar month period, beginning on the Plan Effective Date.

Plan Service Area means the geographical area(s) or areas in which a Network of Providers is offered and available and is used to determine eligibility for Managed Health Care Plan benefits.

Post-Service Medical Necessity Review means the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines. Can also be referred to as a retrospective review or post service claims request.

Primary Care Provider means a Physician or Professir.l3 (ean)-3.7.3 (ed)-3.t-3.7.3 (ed)-3.t-35eoce-3.7 (i)-1.7 (d)-2.8

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2. A staff person with a Registered Behavior Tech (RBT) certification for the direct line therapist effective as of January 1, 2019.

Recommended Clinical Review means an optional voluntary review of a Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

Renal Dialysis Center means a facility which is Medicare certified as an end-stage renal disease facility providing staff assisted dialysis and training for home and self-dialysis.

Research Institution means an institution or Provider (person or entity) conducting a phase I, phase II, phase III, or phase IV clinical trial.

Residential Treatment Center means a facility setting (including a Residential Treatment Center for Children and Adolescents) offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities. Patients are medically monitored with 24 hour medical availability and 24 hour on site nursing service for Mental Health Care and/or for treatment of Substance Use Disorder. BCBSTX requires that any facility providing Mental Health Care and/or a Substance Use Disorder Treatment Center must be licensed in the state where it is located, or accredited by a national organization that is recognized by BCBSTX as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

Residential Treatment Center for Children and Adolescents means a child-care institution which is appropriately licensed and accredited by the Joint Commission on Accreditation of Healthcare Organizations or the American Association of Psychiatric Services for Children as a residential treatment center for the provisions of Mental Health Care and Serious Mental Illness services for emotionally disturbed children and adolescents.

Retail Health Clinic means a Provider that provides treatment of uncomplicated minor illnesses. Retail Health Clinics are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

Routine Patient Care Costs means the costs of any Medically Necessary health care service for which benefits are provided under the Plan, without regard to whether the Participant is participating in a clinical trial.

Routine Patient Care Costs do not include:

1. The investigational item, device, or service itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

1. Bipolar disorders (hypomanic, manic, depressive, and mixed);
2. Depression in childhood and adolescence;
3. Major depressive disorders (single episode or current);
4. Obsessive-compulsive disorders;
5. Paranoid and other psychotic disorders;
6. Schizo-affective disorders (bipolar or depressive); and
7. Schizophrenia.

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2. Medicare or Medicaid eligible as a supplier of skilled inpatient nursing care.

Specialty Care Provider means a Physician or Professional Other Provider who has entered into an agreement with Claim Administrator (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care Provider of specialty services with the exception of a family practitioner, obstetrician/gynecologist, pediatrician, Behavioral Health Practitioner, an internist or a Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these.

Substance Use Disorder means the abuse of or psychological or physical dependence on a drug (other

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recover

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

6. We or Us means Blue Cross and Blue Shield of Texas.

Order of Benefit Determination Rules

1. General Information

   a. When there is a basis for a claim under This Plan and another Plan, This Plan Th Plan 6.

Employer before the end of the initial eighteen (18) month period, coverage may be extended an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

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AMENDMENTS

BENEFIT BOOKLET
NO SURPRISES ACT
AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the P
Yearof Your Employer's Group Health Plan occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the Benefit Booklet to which this Amendment is attached and becomes a part of the Benefit Booklet. Unless otherwise required by Federal or Texas law, in the event of a c between the terms on this Amendment and the terms of the Benefit Booklet, the terms on this Amendment However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purp of this Amendment, references to You and Your mean any member, including Participant and Dependents.

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

If You are under the care of a Participating Provider as defined in the Benefit Booklet who stops participating in th Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompete professional behavior, or fraud), You may be able to continue coverage for that Provider's covered services at network benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for .5 0 Td [(Y).1 (C)rvis an( )5 (w)4 (m)-2p(bl)-2 (e)-1x(o c)-1 the

in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a seri
dysfunction of any bodily organ or part.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Prov

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and fo
Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the
Recognized Amount is used to calculate Your cost-share requirements, including Deductibles, Copayment Amount
and Co-Share Amount.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received
from a Participating Provider, the amount used to calculate Your cost-share requirements, including Deductibles,
Copayment Amounts, and Co-Share Amount, will be the lesser of the Qualifying Payment Amount or billed charg
For Included Services, these cost-share requirements will be counted toward Your in-network Deductible and/or
Out-of-Pocket Maximum, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If You receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the
most the Non-Participating Provider or non-Participating Emergency Facility may bill You is Your in-network cost
share. You cannot be balance billed for these Emergency Services unless You give written consent and give u
protections not to be balanced billed for services You receive after You are in a stable condition.

When You receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility,
the most those Non-Participating Providers may bill You is Your Plan's in

NOTICES

NOTICE

Other Blue Cross and Blue Shield Plans Separate Financial Arrangements with Providers

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1.

NOTICE

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator J 0.23 0 TD [(ar)3OnaSc(cJ 0.23 0 TD1)4.4 (r)2.7 ( )-5o3w 0.2ar

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY BE RESPONSIBLE FOR PAYMENT OF ALL OR PART OF THE FEES FOR THOSE PROFESSIONAL SERVICES THAT ARE NOT PAID OR COVERED BY YOUR HEALTH BENEFIT PLAN.

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

NOTE: Certain employers may not be affected by CONTINUATION OF COVERAGE AFTER TERMINATION (COBRA). See your employer or Group Administrator should you have any questions about COBRA.

INTRODUCTION

You are receiving this notice because you have recently become covered under your employer's group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may be available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations

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Information Provided by your Employer

Health Plan Supplement

Health Care Benefit Program
Prescription (Rx) Drug Program
Employee Assistance Plan
The Wellness Plan

INTRODUCTION

CARES maintains the CARES Health Plan, for the exclusive benefit of and to provide welfare benefits to the eligible employees of the CARES Member Schools, their spouses and eligible dependents. The welfare benefits under the CARES Health Plan include medical benefits, prescription drug benefits, an employee assistance program and a wellness program. This Supplement describes the eligibility provisions for all of the welfare

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HOW TO ENROLL, WHEN YOUR COVERAGE BEGINS AND CHANGING YOUR ELECTIONS 5
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PRESCRIPT

- If a Retired Participant terminates participation in the Plan for any reason other than for death or eligibility for Medicare, the Dependents of such Retired Participant shall terminate participation in the Plan as of the Retired Participant's termination of participation: and

- When a Retired Participant or covered Dependent who was not eligible for Medicare coverage becomes eligible for Medicare, participation in the Plan will terminate as of the date in which the Retired Participant or Dependent becomes eligible for Medicare

CONTRIBUTIONS

You and Your Employer share the cost of coverage under the Plan. The formula used for determining the amount of Employee contributions is approved by CARES, and may change from time to time.

Generally, Employee contributions toward the cost of coverage are paid for on a pre-tax basis. However, due to current tax laws, coverage for Dependents can be paid for on a pre-tax basis only if the Dependent is your spouse, is your biological child, adopted child, stepchild or child for whom you are the legal guardian, or if the Dependent meets the IRS's definition of a tax dependent under Section 152 of the Internal Revenue Code.

HOW TO ENROLL, WHEN YOUR COVERAGE BEGINS, AND CHANGING YOUR ELECTIONS

ENROLLMENT

Coverage under the Employee Assistance Program is automatic and begins on your first day of employment.

If you elect coverage under the Health Care Benefit Program you will be automatically enrolled in the Prescription (Rx) Drug Program.

WHEN COVERAGE BEGINS

If you are a new Full-Time Employee of a Member School, your coverage and your Dependents' coverage as applicable will begin on the first day of the month following your first day of work, assuming you complete the enrollment process within 31 days of your first day of work. If you are not actively at work due to a health factor, your absence will be counted for purposes of determining eligibility.

If you fail to complete the enrollment process within 31 days of your first day of work, you will be considered to have waived benefits. Your next opportunity to enroll is during the Open Enrollment period, unless a special enrollment event or a change in status occurs which would entitle you to mid-year enrollment.

OPEN ENROLLMENT PERIOD

The Plan holds an annual "Open Enrollment" period each year. During this Open Enrollment period, individuals who are currently enrolled or who are eligible to enroll in the Plan may make changes to their (e)3 (n)-1.I1 (>BDC -0.0(r)7.9 ((e)11.8r)-6.9 u(n E)4.9 5 (c)2 (a)4.9 (oMCID 24 >>.8 di70.0 (o)11 (d)(a)4

CHANGING ELECTIONS

Generally, your elections for coverage under the CARES Health Plan cannot be changed other than at the annual Open Enrollment Period, as described above. However, there are two types of events which would permit you to change your election: special enrollment and a change in status.

Special Enrollment

If you decline enrollment for yourself or your Dependents (including your Spouse) because of other health

Effective Date for Special Enrollment. Coverage elected pursuant to a special enrollment event will become effective as follows:

(a) in the case of a loss of coverage or marriage, the date of the loss of coverage or marriage, provided that special enrollment is timely requested;

(b) in the case of a Dependent's birth, adoption, or placement for adoption, the date of the birth, adoption, or placement for adoption, respectively, provided that special enrollment is timely requested and the Dependent is properly enrolled in the Plan within 60 days after birth or placement for adoption;

(c)

- the Plan is amended or terminated, but only with respect to expenses incurred after the amendment or termination becomes effective; or
- you or your provider fails to file a claim within 12 months of the date service is provided.

Erroneous Claims and Administrative Errors

If the Plan Administrator determines that a benefit was paid under the Plan that either (a) exceeds the covered expenses or (b) was paid in error (for example, if the Plan provided coverage to an ineligible or unverified dependent), you will be required to repay to the Plan the improperly covered benefits. The Plan provides that the Plan Administrator in its discretion may recoup the improperly covered benefits under any methods of collection available, including any of the following:

- notification to you of the error, and an accompanying request that you immediately pay the amount of the improperly covered benefit as directed by the Plan Administrator;
- offsetting the amount of the improperly covered benefit against any other eligible Plan benefits (regardless of the Plan Year in which it is submitted); and
- if permissible under applicable law, withholding the amount of the improperly covered benefits from your pay on a pre-tax basis.

Disclaimer

Employees of the Member Schools, Claims Administrator and/or employees of CAREM(o)11 5 43axE dtJ 0.5 (to

HEALTH CARE BENEFIT PROGRAM

Employees, their Eligible Dependents (including Spouses), and Retired Participants

Please refer to the booklet prepared by BCBSTX for a description of the medical benefits provided to you and your eligible dependents under the Health Care Benefit Program.

Primary Care Provider

The Health Care Benefit Program option you elect under the Plan may require the designation of a primary care provider. You have the right to designate any primary care provider who participates in BCBSTX's network and who is available to accept you and your family members. Until you make this designation, BCBSTX may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact BCBSTX or refer to your booklet (see the "Plan Identifying Information" section of this Supplement for BCBSTX's contact information).

For children, you may designate a pediatrician as the primary care provider.

Obstetrical and Gynecological Care

You do not need prior authorization from BCBSTX or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the BCBSTX's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact BCBSTX (see the "Plan Identifying Information" section of this Supplement for BCBSTX's contact information).

HDHP Prescription Drug Program

If you elected to be covered under the "high deductible health plan" option offered under the Health Care Benefit Program, your prescription drugs will be covered in accordance with the following schedule:

Annual Deductible	
Individual Family	You pay 100% of the cost of covered prescriptions until you meet the annual plan deductible (combined for medical and prescription drugs): $3,000 $6,000
Out-of-Pocket Maximum	
Coinsurance Individual Family	Copays apply after deductible has been met $6,450 $12,900
Retail Prescription Drugs (30-day supply)	
Generic Drugs (Tier 1)	$10 copay
Preferred Formulary Drugs (Tier 2)	$35 copay
Non-Preferred Formulary Drugs (Tier 3)	$50 copay

How the Prescription (Rx) Drug Program Works

Prescription benefits are administered through RxBenefits in combination with Express Scripts ("ESI"). Upon enrollment, BCBSTX will mail a combined Medical/Pharmacy identification card to you and will also provide an additional card for your family members.

Retail Pharmacy Service

- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent;

- injectable infertility drugs and injectable drugs that require physician supervision and are not typically considered self-administered drugs. The following are examples of physician supervised drugs: injectables used to treat hemophilia and RSV, chemotherapy injectables and endocrine and metabolic agents;

- any drugs that are deemed to be experimental or investigational;

- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the

EMPLOYEE ASSISTANCE PROGRAM (“EAP”)

ELIGIBILITY

All Employees and their family members (living in the Employee’s home) of Member Schools have access to the EAP, regardless of whether they are enrolled in the CARES Health Plan.

BENEFITS

The Employee Assistance Program (“EAP”) is available 24 hours a day, seven days a week, with trained and licensed counselors who can provide confidential advice, counseling, and referral services to assist you and the members of your household in resolving a full range of human life, family, work or health problems. You and the members of your household are eligible for the EAP on the first day of your employment. The “members of your household” for purposes of the EAP include individuals who permanently, physically reside in your household, or who meet the requirements to be considered your tax dependent under Section 152 of the

THE WELLNESS PLAN

For 2023, The University will continue offering its wellness program to reward everyone who participates and completes the listed activities below by October 31, 2022, either $50/month premium credit in the PPO plans or $50/month HSA employer contribution in the HDHP plan:

- Register with Mobile Health and complete an online health risk assessment

- Complete a biometric screening on-site via eHealthScreenings or as an alternative to an on-campus screenings. Employees may use their existing health care provider using the PCP/Lab form provided by eHealthScreenings for this screening.

- 24/7 Nurseline – Nurses guide members to the appropriate level of care for their health issue, answer general health questions and direct members to an audio library of 1,000+ health topics. They can also access benefits information to direct members to other programs that may be helpful.

Benefits for All Employees

The following benefits are availa9 (g)1.3n.8 (r)-5 037 oe a(ila)m37 o79 (go.6 (h)-y3 (a))1.3n1.8 (e)2.5 (s)-5.5

MDLIVE

When you just can't get to the doctor

MDLIVE gives you 24/7/365 access to U.S. board-certified doctors through the convenience of a phone call. This is a great alternative to Urgent Care and Emergency Room visits because services you receive through MDLIVE are a part of the medical plan. An MDLIVE doctor can give you a diagnosis. The doctor can even prescribe medications if needed.

When Can I use MDLive?

When you need care and:

- You are considering the Emergency Room or Urgent Care Clinic for a non-emergency issue
- You are on vacation, on a business trip, or away from home
- Short-term prescription refills

Get the Care You Need

MDLIVE doctors can treat many medical conditions, including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infections
- Respiratory infections
- Sinus problems

Ways to connect

You can easily activate your account or connect with an MDLIVE doctor by using one of the following methods:

- Phone: 888-726-3171
- Website: www.mdlive.com
- Download the MDLIVE App from the App Store

OTHER IMPORTANT INFORMATION

subject the covered person to severe pain that could not be adequately managed without the care or treatment

Pre-Service Claim (Prescription (Rx) Drug Program Only)

A Pre-Service Claim means any Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care, i.e., for example, Claims subject to pre-authorization (PA) under the prescription plan.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim. In other words, a Claim that is a request for payment under the Plan for covered medical services already received by the covered person or for which no prior approval was required.

In the case of a Post-Service Claim, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted

a statement will be included that such rule, guideline, protocol, or criterion was relied upon in making the

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The IRO will provide you with a written notification that it has received and

The IRO will follow the review process described above, and

CONTINUING COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

A federal law called "COBRA" requires the Plan to offer Participants the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan otherwise would end due to the occurrence of a "qualifying event." Thus, in accordance with COBRA, if you are no longer eligible to participate in the Plan due to a qualifying event, you and your covered spouse and covered dependents will be entitled to continue coverage under COBRA with respect to those benefit programs. If you elect to continue coverage under the Health Care Benefit Program, your coverage under the Prescription (Rx) Drug Program, EAP and The Wellness Plan will automatically be continued.

The booklet provided by Blue Cross Blue Shield of Texas describes how you can continue your coverage under COBRA.

Please note that, for purposes of COBRA

- to the Department of Health and Human Services for purposes of determining the Plan's compliance with these privacy rules;
- to coroners, medical examiners, and funeral directors (for example, to identify a deceased person or determine the cause of death);
- for national security and intelligence activities; and
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- CARES shall make your PHI available to you for amendment and incorporate any amendment i your PHI (as described below); and

- CARES shall make available the information required to provide you an accounting of disclosures (as described below).

Access to PHI

The Plan will make your PHI available to you for inspection and copying upon your written request to the applicable Insurance Company. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

Amendment of Medical Information

If you feel that PHI the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. Your request must be made in writing and submitted to the applicable Insurance Company. In addition, you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask the Plan to amend information that is not part of the medical information kept by or for the Plan; was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; is not part of the information which you would be permitted to inspect and copy; or is accurate and complete.

Accounting of Disclosures

If you wish to know to whom your PHI has been disclosed for any purpose other than (a) treatment, payment, or health care operations, (b)

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report form the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court subsequent to exhausting the Plan's claims procedures. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court subsequent to exhausting the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Secure te or Ienen261 0(t)-4.1 (r)

(4) Your unmarried child who is age 26 or older and who:

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PLAN IDENTIFYING INFORMATION

This section provides administrative information for the Plan, subject to the terms of the legal documents, which may be modified from time to time. Where this description and the official documents differ, the official plan documents or insurance booklets/contracts are the final authority. This description of administrative information is not an employment contract or any type of employment guarantee.

The Plan Administrator will help resolve any problem you might have about your rights to benefits. The official plan documents, insurance contracts, and related information are available if you want to review these materials. If, for some reason, it becomes necessary to contact the U.S. Department of Labor, you will need to provide the information contained in this section to identify the plan properly.

Name of the Plan	Collegiate Association REsource of the Southwest, Inc. Health Plan
Plan Number	501
Plan Sponsor and its IRS Employer Identification Number	Collegiate Association REsource of the Southwest, Inc. 3824 Cedar Springs Rd #583 Dallas, TX 75219 (972) 663-7304 EIN: 68-0589116
Plan Sponsors/Member Schools	University of Dallas 1845 E. Northgate Drive Irving, TX 75062 (972) 721-5000 Austin College 900 N. Grand Avenue Sherman, TX 75090-4400 (903) 813-2000 The specific terms and conditions of the Plan applicable to a Member School are detailed in a separate summary plan description for that Member School. By writing the Plan Administrator at the address listed below, you can receive information as to whether a particular employer is a