TX Health BENEFITS POOL

2024-2025

DENTAL PLAN BOOK

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FOREWARD

TX Health Benefits Pool has prepared this booklet to help you understand the dental benefits provided through your Employer. The Dental Plan described in this booklet provides coverage for a wide range of dental care, services, and supplies. However, your benefits are affected by certain limitations and conditions that require you to be an informed consumer of dental services and to use only those services you need. Treatment that is not dentally based or evidence based is not a covered benefit, even if recommended or prescribed by your dentist. Please review the **Dental Limitation and Exclusions** section. TX Health Benefits Pool urges you to familiarize yourself with the provisions in the Plan description in order to understand your Benefits. There is a glossary of healthcare definitions in the back of the book to assist you with your understanding of healthcare services.

The Plan is not intended to cover the entire cost of dental care. It is provided to you, by your Employer, to assist you with your dental care expenses.

Disclaimer: *A new benefit booklet is distributed at the beginning of the plan year. Additionally, amendments may be made throughout the year if material updates are made. Please verify the annual date referenced on the front cover of the Dental Benefits Booklet to make sure you are referring to the dental benefits that coordinate with the Incurred service date.*

About TX Health Benefits Pool

TX Health Benefits Pool is a risk pool created under and governed by the Texas Political Subdivisions Uniform Group Benefits Program (Chapter 172 Texas Local Government Code). Section 172.014 of that chapter provides that "A risk pool created under this Section is not insurance or an insurer under the Insurance Code or other laws of this state."

Group Benefit Dental Plan for TX Health Benefits Pool*

This notice certifies that TX Health Benefits Pool has accepted your Employer as a risk-participating member of TX Health Benefits Pool. Your Employer has selected a Plan of Benefits and may have the responsibility for compliance with state and federal laws applicable to employee benefits. However, for some state and federal laws applicable to a health plan based upon the number of Employees enrolled or eligible to enroll in the health plan, the size of the health plan is determined by the number of individuals enrolled in TX Health Benefits Pool as a whole and not based on any one Employer's number of Employees. This is a governmental plan excluded from coverage under ERISA (29 U.S.C.A. 1003(b)).

The Plan covers Actively-At-Work Employees, Dependents of Actively-At-Work Employees, elected officials, Dependents of elected officials, pre-sixty-five Retirees, and Dependents of pre-sixty-five Retirees of Pool Members who are eligible for coverage, become covered, and continue to be covered according to the terms of the Plan, Pool policies, and of the Employer's dental Benefits. In case of a conflict between a TX Health Benefits Pool plan provision, policy rule, regulation, or underwriting guideline and Employer coverage, the TX Health Benefits Pool plan provision, policy rule, regulation, or underwriting guideline shall override the Employer coverage in deciding whether an individual is eligible for coverage or whether a Benefit should be paid. The Board of Trustees of TX Health Benefits Pool reserves the right to amend the Plan if circumstances warrant and has given the Executive Director the discretionary authority to construe the terms of the Plan.

**A Risk Pool created under and governed by the Texas Political Subdivisions Uniform Group Benefits Program (Chapter 172 Texas Local Government Code). Section 172.014 of that chapter provides that "A risk pool created under this Section is not insurance or an insurer under the Insurance Code or other laws of this state, and the State Board of Insurance [now the Texas Department of Insurance] does not have jurisdiction over a pool created under this Section.*

Read Your Benefit Booklet Carefully

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 dental care expenses for Dentally 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 affects your dental 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. In the event of any conflict between any components of this Plan, the Benefit Program Application provided to your Employer by BCBSTX prevails.

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 any Participant, including Subscriber and Dependents.

This Benefit Booklet Replaces, In Its Entirety, All Previously Issued Benefit Booklets.

Dental Customer Service Helpline

Dental Customer Service Representatives can:

1. Give you information about Contracting Dentists;
2. Distribute claim forms;
3. Answer your questions on claims;
4. Assist you in identifying a Contracting Dentist (but will not recommend specific Dentists);
5. Provide information on the features of the Plan.

BCBSTX Website

Visit the BCBSTX website at www.bcbstx.com for information about BCBSTX, access to forms referenced in this Benefit Booklet, and more.

Important Contact Information

Questions About...	Contact	Hours
• Enrolling in benefits • Adding, removing, or changing any TX Health Benefits Pool administered benefit • Changing your contact information • TX Health Benefits Pool website • TX Health Benefits Pool Online password reset • General questions	TX Health Benefits Pool Member Services **800-282-5385**	Monday – Friday 8am - 5pm CDT
• Dental benefits • Dental procedures • Dental claims, EOBs • Deductibles, co-payments, coinsurance	Blue Cross and Blue Shield of Texas Helpline **855-762-6084**	Monday – Friday 8am – 8pm CDT
• TX Health Benefits Pool Online access • Access to benefits books • Health and wellness resources	TX Health Benefits Pool Website www.txhb.gov	24/7
• Blue Access for Members (BAM) • Find an In-Network provider	BCBSTX Website www.BCBSTX.com	24/7

WHO GETS BENEFITS

Eligibility Requirements for Coverage

The names, social security numbers, sex, and birth dates of all persons in a family Enrolling in the Plan will be provided to us through our online enrollment system, TX Health Benefits Online, (TXHBO), or an approved method determined by your employer. You may be required to submit supporting documentation to show your Dependents are eligible under the Plan.

No eligibility rules or variations in cost will be imposed based on your health status, medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of your race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes, or benefits of this Plan that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives, and/or other programs do not constitute discrimination.

Initial Enrollment (New Hire Enrollment)

To receive coverage, new hires, and newly eligible Employees and their Dependents must Enroll in the Plan in a timely manner. We must receive enrollment within thirty-one (31) days of the date of hire or by the coverage effective date, whichever is later, regardless of whether the Employer has an orientation period. If you are not Enrolled in a timely manner, you and any Dependents cannot be added to the Plan until the next Open Enrollment period, or a Qualifying Life Event occurs.

Upon timely enrollment, coverage will begin the later of*:

1. The date you became an Actively-At-Work Employee working at least twenty (20) hours per weeks; or
2. The date you complete any Waiting Period established by your Employer.

Enrollment Participation Requirements

For employers who select a non-voluntary product, TX Health Benefits Pool requires groups to enroll 100% of their benefit eligible employees. This is also known as the 100% Participation Rule. Employers may have employees that wish to waive dental coverage through TX Health Benefits Pool, however, waivers may only be granted for the following reasons:

1. You were hired after retiring and receiving dental coverage through your previous employer due to retirement;
2. You are under age 26 and has dental coverage through your parent;
3. You are covered by your spouse's dental plan;
4. You are covered by the Veterans Administration (VA) or TRICARE without receiving an incentive by the organization;
5. You are enrolled in Medicare without receiving an incentive by the organization;
6. You are enrolled in Tribal Medical coverage;
7. You are employed by another employer and are enrolled in the other employer dental plan;
8. You were enrolled in a qualified health or medical plan prior to employment with the organization and choose to keep that medical plan. **A qualified health plan is a plan that provides all essential health benefits as defined by the ACA and follows established limits on cost sharing.**

Annual Open Enrollment

During the Open Enrollment period, you can make changes to your enrollment, such as adding or dropping Dependents.

Changes made during Open Enrollment will become effective on the Plan's effective date. If the Open Enrollment information is not received by us within the Open Enrollment period, you and your Dependents may not be Enrolled.

Qualifying Life Events

A Qualifying Life Event ("QLE") is an event you experience that may alter your need to acquire or make changes to your coverage. If you experience a QLE, you will be eligible for a Special Enrollment Period that enables you to make changes to your coverage such as adding or dropping a dependent, enrolling in or discontinuing your coverage, changing a flexible spending account, or other changes consistent with the QLE. All changes must be made within 31 days of the QLE. The IRS determines what constitutes a QLE, but some common examples of events that are considered a QLE include:

1. Marriage;
2. Birth, adoption, or placement for adoption of a Child;
3. Divorce of the Employee;
4. Death of the Employee or someone who shares your health plan;
5. Turning 65;
6. Turning 26 and aging out of parents' insurance coverage;
7. Certain residence changes such as moving to a new county;
8. Gaining or losing employment resulting in gaining or losing health coverage, or
9. Loss of dental coverage.

For more details on when you qualify for a Special Enrollment Period, see regulations implementing the Affordable Care Act in the Code of Federal Regulations, Title 45, Section 146.117 (45 CFR 146.117).

Changes are effective the first of the month following your qualifying life event date except for the birth of a child, adopting a child and gaining a medical support order (MSO) in which coverage takes effect as of the QLE date.

QLE changes may be entered in TXHBO for most employers, or through an approved method by your employer, and must be submitted within 31 days of the event along with any required documentation. If you do not request the change within 31 calendar days, the next opportunity you will have to make changes to your benefits will be during the next Open Enrollment period. Refer to IRS 26 CRF 1.125-4 – Permitted elections changes.

Adding a Newborn*, or Newly Adopted Child

When adding a newborn or newly adopted Child, you must make enrollment changes within thirty-one (31) days. The fact that you have other Dependent Children, covered does not automatically extend coverage to a newborn.

When adding Dependents due to loss of eligibility under Medicaid or a State Children's Health Insurance Program (SCHIP), you must make enrollment changes within thirty-one (31) of loss of coverage.

Retirement

If your Employer offers retiree coverage, we must receive your enrollment information within thirty-one (31) days of the commencement of your retirement. If you Enroll, coverage will begin the date you become a Retiree.

Upon retirement, if you Enroll in Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage, the Retiree Medical Benefit will not be an option at the termination of COBRA.

Retiree Pool coverage is terminated upon Medicare eligibility at age sixty-five (65).

Active Duty Reservists

If covered by the Plan as an Employee at the time of call to active duty, active-duty reservists or guard members and their covered Dependents can maintain eligibility on the Plan for up to twenty-four (24) months as prescribed by and subject to the terms and conditions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). The date on which absence begins is the Qualifying Event for COBRA to be offered to you as a reservist or guard member.

If a firefighter or police officer is called to active duty for any period, the Employer must continue to maintain any health, dental, or life coverage received on the date the firefighter or police officer was called to active military duty until the Employer receives written instructions from the firefighter or police officer to change or discontinue the coverage. Such instruction shall be provided no later than sixty (60) days following the Qualifying Event. If no such instruction is given, then coverage will terminate on the sixty-first (61st) day, which shall then become the Qualifying Event for COBRA purposes. Eligibility will meet or exceed requirements of USERRA and/or regulatory compliance. In administering this coverage, we will follow the time guidelines of COBRA under 42 U.S.C.A. 300bb-1 et seq. To qualify for this coverage, you must give written notice to the Employer within sixty (60) days of the Qualifying Event. The Employer must notify us that an Employee has been called to active duty and submit a copy of the Employer's Active Reservist Policy.

Under USCA § 4316, an Employee who is called for military leave may have rights to COBRA for up to twenty-four (24) months and a right to reemployment once discharged from active military service.

If you will be on active duty for thirty-one (31) days or less, the Employer will keep you on the Plan with no change in coverage. If you will be on active duty for more than thirty- one (31) days, the Employer will notify us of the Qualifying Event and submit a copy of your written order for call to duty.

If your Employer has elected to have TX Health Benefits Pool administer COBRA, the Employer must notify us by sending a Qualifying Event Notice and mark the Qualifying Event "Called to Active Duty" and attach a copy of your written order for the call to duty. The Employer must notify TX Health Benefits Pool timely of the termination if call to active duty is more than thirty- one (31) days to avoid negative consequences described below.

Important Notification Requirements

If the Employer administers their own COBRA or uses a third-party administrator other than TX Health Benefits Pool, the Employer must notify us of the termination if call to active duty is more than thirty-one (31) days. The Employer is responsible for all required notices, and any consequences resulting from delayed notice.
Delays in notification can lead to interruption in coverage, unpaid claims or other negative consequences for which TX Health Benefits Pool is not responsible.

Civil Service Coverage Continuation Rights

Section 143.072, Texas Local Government Code may require an Employer to "continue to maintain" coverage on a police officer or firefighter while on military leave if the Employer has adopted civil service requirements and the leave has been approved by the Firefighters' and Police Officers' Civil Service Commission. This Section only applies if the Employer meets the requirements of Chapter 143 of that Code, including having a population of 10,000 or more and having voted to adopt the applicable provisions of the law.

For you, an individual nineteen (19) years of age or older, to return to the Employer's Plan and continue your Benefits with no Waiting Period, you must return to work as an Employee within the time period required by state and federal law for such return.

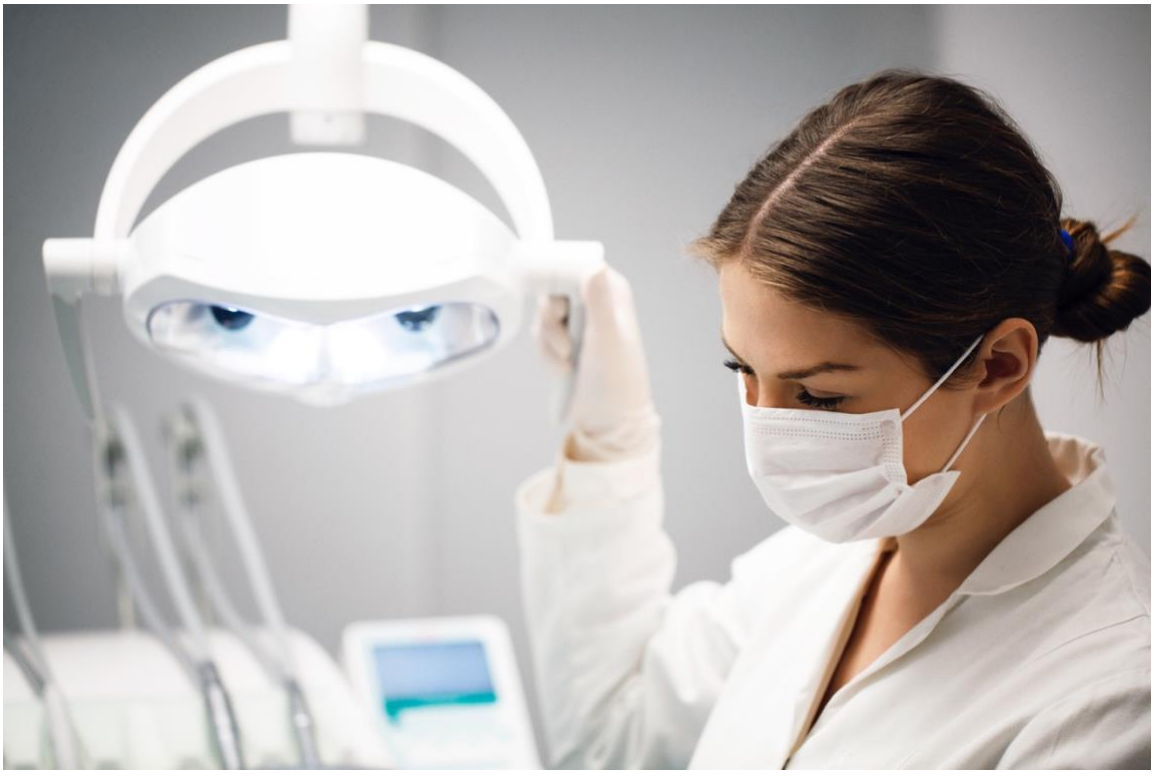
The additional 2% of Contributions is not charged for you when called to active duty.

COBRA Eligibility

If you meet certain requirements under federal law, you may qualify for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). References to COBRA coverage in this Plan Book are not a guarantee of coverage, your eligibility for such coverage depends on whether you and your Employer meet specific criteria under USC Chapter 18, eligibility for such coverage depends on whether you and your Employer meet specific criteria under 29 USC Chapter 18, Subchapter I, Subtitle B, Part 6. See the Continuation Coverage Rights Under COBRA section at the end of this book.

TX Health Benefits Pool may or may not administer COBRA for your Employer, depending on your Employer's election when they joined the TML Health risk pool. If we do administer COBRA, your access to coverage depends in part on your Employer sending us timely and appropriate notifications. Your Employer's failure to meet its obligations may negatively impact your eligibility for coverage.

For more information regarding COBRA coverage, refer to the COBRA Notice in the Required Notices section of this plan booklet.



HOW THE PLAN `

Allowable Amount

Review the definition of Allowable Amount in the DEFINITIONS section of this Benefit Booklet to understand the guidelines used by BCBSTX.

Course of Treatment

Your Dentist may decide on a planned series of dental procedures which a dental exam shows you need. In cases where there is more than one professionally acceptable procedure or Course of Treatment, benefits will be covered for the least costly procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the Participant is responsible for expenses that exceed the amount covered for the least costly service.

Current Dental Terminology (CDT)

The most recent edition of the manual published by the American Dental Association (ADA) entitled "Current Dental Terminology and Procedure Codes (CDT)" is used when classifying dental services.

The Allowable Amount for an Eligible Dental Expense will be based on the most inclusive procedure codes.

Freedom of Choice

In each event as described above, you will be responsible for the following:

1. Any applicable Deductibles;
2. Coinsurance Amounts;
3. Services that are limited or not covered under the Plan, including service provided by a non-contracted dentist if your plan does not cover services from an out-of-network provider. Refer to your Schedule of Dental Benefits for information regarding the reimbursement of out-of-network services.

For plans that allow access to both contracting and non- contracting dentists, your benefits are better with a contracting dentist.

- Your out-of-pocket maximum will generally be the least amount because Contracting Dentists have contracted to accept a lower Allowable Amount as payment in full for Eligible Dental Expenses;
- You are not required to file claim forms;
- You are not balance billed for costs exceeding the BCBSTX Allowable Amount for Contracting Dentists.

To find a Contracting Dentist, you may look up a dental Provider in the Dental Directory, log on to the Blue Cross and Blue Shield of Texas website at www.bcbstx.com and search for a Dentist using Provider Finder, or call the Dental Customer Service Helpline number located in this Benefit Booklet or on your Identification Card.

How Benefits are Calculated

Your benefits are based on a percentage of the Dentist's Allowable Amount. To determine your benefits, subtract the Deductible (if applicable and not previously satisfied) from your Dentist's Allowable Amount. Then, multiply the difference by the Coinsurance Amount percentage applicable to the benefit category of services shown on your Dental Schedule of Coverage. The resulting total is the amount of benefits available.

The remaining unpaid amounts, including any Deductible, your Coinsurance Amount, or services not covered by your plan will be your responsibility to pay to your Dentist.

For some plans, you may be required to use a BlueCare contracted dentist to receive benefits under the plan. Check your Dental Schedule of Coverage to determine if you have access to both network and out-of-network dentists.

Identification Card

The Identification Card tells Providers that you are entitled to benefits under your Employer's dental care Plan with BCBSTX. The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

Blue Cross and Blue Shield of Texas as your Claim Administrator.
Your group number. This is the number assigned to identify your Employer's dental care Plan with BCBSTX
Important telephone numbers.

Always remember to carry your Identification Card with you and present it to your Dentist when receiving dental care services or supplies.

Unauthorized, Fraudulent, Improper, or Abusive Use of Identification Cards

The unauthorized, fraudulent, improper, or abusive use of Identification Cards issued to you and your covered Dependents will include, but not be limited to, the following actions, when intentional:

1. Use of the Identification Card prior to your Effective Date;
2. Use of the Identification Card after your date of termination of coverage under the Plan;
3. Obtaining benefits for persons not covered under the Plan; and/or
4. Obtaining benefits that are not covered under the Plan.

The fraudulent or intentionally unauthorized, abusive, or other improper use of Identification Cards by any covered individual can result in, but is not limited to, the following sanctions being applied to all individuals covered under your coverage:

1. Denial of benefits;
2. Cancellation of coverage under the Plan for all individuals under your coverage;
3. Recoupment from you or any of your covered Dependents of any benefit payments made;
4. Pre-approval of drug purchases and medical services for all individuals receiving benefits under your coverage; and/or,
5. Notice to proper authorities of potential violations of law or professional ethics.

Please remember that any time a change in your family takes place, it may be necessary for a new Identification Card to be issued to you (refer to the WHO GETS BENEFITS section for instructions when changes are made). Upon receipt of the change in information, BCBSTX will provide a new Identification Card.

CLAIM FILING AND APPEALS PROCEDURE

Claim Filing Procedures Claim Forms

Claim forms are not required for Benefits to be payable under the Plan. We may request specific information from you or your Employer in order to complete processing of the claim or to verify eligibility in the Plan. The information requested may include but is not limited to:

1. verification of employment status;
2. information related to accidental injuries;
3. information related to work-related accidents or illness; and/or
4. information regarding any other source of benefits.

Who Files Claims Provider-filed Claims

Contracting Dentists will usually submit your claims directly to BCBSTX for services provided to you or any of your covered Dependents. At the time services are provided, inquire if they will file claim forms for you. To assist Dentists in filing your claims, you should carry your Identification Card with you.

Participant-filed Claims

If your Dentist does not submit your claims, you may need to submit them to BCBSTX using a Participant-filed claim form provided by BCBSTX. You can obtain copies from the BCBSTX website at bcbstx.com, or by calling Customer Service at the toll-free number on your identification card. Follow the instructions on the form to complete the claim. Remember to file each Participant's expenses separately because any Deductibles, maximum benefits, and other provisions are applied to each Participant separately. Include itemized bills from the Dentist printed on their letterhead and show the:

1. Services performed;
2. Dates of service;
3. Charges; and
4. Name of the Participant involved.

Visit the BCBSTX website for dental claim forms and other useful information: www.bcbstx.com.

Where to Mail Completed Claim Forms

Blue Cross and Blue Shield of Texas Dental Claims Division
P. O. Box 660247
Dallas, Texas 75266-0247

Who Receives Payment

Benefit payments will be made directly to the Dentists when they bill the claim to BCBSTX. Written agreements between BCBSTX and some Dentists may require payment directly to them. Any benefits payable to you, if unpaid at your death, will be paid to your beneficiary or to your estate, if no beneficiary is named.

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:

1. The third party is named in a Court Order as managing or possessory conservator of the child; and
2. BCBSTX has not already paid any portion of the claim.

TXHB must receive the full court order naming the conservator of the child along with a completed BCBSTX Confidential Communication Request Form. The documents may be mailed, faxed, or emailed to ebmail@txhb.gov

For benefits to be payable to a managing or possessory conservator of a child, the conservator must submit to BCBSTX Claim Administrator, with the claim form, proof of payment of the expenses and a certified copy of the Court Order naming that person the managing or possessory conservator.

BCBSTX may deduct from its benefit payment any amounts it is owed by the recipient of the payment. Payment to you or your Dentist, or deduction by BCBSTX from benefit payments of amounts owed to the BCBSTX, will be considered in satisfaction of its obligations to you under the Plan.

An Explanation of Benefits (EOB) for Dental Care summary is sent to you so you will know what has been paid.

When to Submit Claims

All claims for benefits under the Plan must be properly submitted within ninety (90) days of the date you receive the services or supplies. Claims not submitted and received by BCBSTX within twelve (12) months after that date will not be considered for payment of benefits except in the absence of legal capacity.

Receipt of Claims by BCBSTX

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

Review of Claim Determinations

Claim Determinations

When BCBSTX receives a properly submitted claim, it has authority and discretion under the Plan to interpret and determine benefits in accordance with the Plan provisions. You have the right to seek and obtain a review by BCBSTX of any determination of a claim, or any other determination made by BCBSTX of your benefits under the Plan.

No Replacement for Workers' Compensation

The Plan does not replace Workers' Compensation or provide any Benefits if any Workers' Compensation Benefit was paid or could have been paid, whether or not the Employer is a subscriber or non-subscriber in a Workers' Compensation Program, including those individuals who could have been lawfully covered by Workers' Compensation as volunteers. For the purposes of this booklet, work on your family farm or ranch is not considered an employment arrangement requiring Workers' Compensation.

If a Claim Is Denied or Not Paid in Full

If the claim is denied in whole or in part, you will receive a written notice from BCBSTX with the following information, if applicable:

The reasons for the determination;

1. A reference to the benefit Plan provisions on which the determination is based;

2. A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings. Upon request, treatment codes with their meanings and the standards used are also available;
4. An explanation of the BCBSTX internal review/appeals and external review processes (and how to initiate a review/ appeal or external review) and a statement of your rights, if any;
5. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
6. Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
7. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's dental circumstances, if the denial was based on Dental Necessity, Experimental/Investigational treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request; and
8. Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are two types of claims as defined below.

1. Pre-Service Claim is any request for benefits or a determination with respect to which the terms of the benefit Plan condition receipt of the benefit on approval of the benefit in advance of obtaining dental care.
2. Post-Service Claim is notification in a form acceptable to BCBSTX that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the claim charge, and any other information which BCBSTX may request in connection with services rendered to you.

Pre-Service Claims

Type of Notice	*Timing*
BCBSTX must notify you of the claim determination (whether adverse or not):	
If we have received all information necessary to complete the review, within:	*2 working days of the receipt of the complete claim or 3 calendar days of the request, whichever is sooner, if the claim is approved; and 3 calendar days of the request, if the claim is denied.*

Post-Service Claim

Type of Notice	*Timing*
If your claim is incomplete, BCBSTX must notify you within:	*30 days*
If you are notified that your claim is incomplete, you must then provide completed claim information to BCBSTX	*45 days after receiving notice*

BCBSTX must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete, within:	30 days*
After receiving the completed claim (if the initial claim is incomplete), within:	45 days

**This period may be extended one time by BCBSTX for up to 15 days, provided that BCBSTX both: (1) determines that such an extension is necessary due to matters beyond the control of the Plan and (2) notifies you in writing, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which BCBSTX expects to render a decision.*

Claim Appeal Procedures - Definitions

An "Adverse Benefit Determination" means a denial, reduction, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, or failure to provide in response to a claim, or Pre-Service Claim, or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental/Investigational or not Dentally Necessary or appropriate. If an ongoing course of treatment had been approved by BCBSTX and BCBSTX reduces such treatment (other than by amendment or termination of the Employer's benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A Rescission of coverage is also an Adverse Benefit Determination.

How To Appeal An Adverse Benefit Determination

You have the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for preauthorization, or any other determination made by BCBSTX in accordance with the benefits and procedures detailed in your Plan. An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a dental care Provider may appeal on their own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call BCBSTX at the number on the back of your Identification Card.

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

1. Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to BCBSTX to request a claim review. BCBSTX will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:
   Dental Claim Review Section Blue Cross and Blue Shield of Texas
   P. O. Box 660247
   Dallas, Texas 75266-0247
2. BCBSTX will honor telephone requests for information; however, such inquiries will not constitute a request for review.
3. In support of your claim review, you have the option of presenting evidence and testimony to BCBSTX. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments, and additional dental information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process. BCBSTX will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in

the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. If the initial benefit determination regarding the claim is based in whole or in part on a dental judgment, the appeal determination will be made by a Dentist associated or contracted with BCBSTX and/or by external advisors, but who were not involved in making the initial denial of your claim.

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

Timing of Appeal Determination

BCBSTX will render a determination on an appeal of an Adverse Benefit Determination as soon as possible but not later than 30 days after the appeal has been received by BCBSTX.

If You Need Assistance

If you have any questions about the claims procedures or the review procedure, write or call BCBSTX at **855-762-6084.** The BCBSTX Customer Service Helpline is accessible 24/7.

Dental Claim Review Section Blue Cross and Blue Shield of Texas
P. O. Box 660247
Dallas, Texas 75266-0247

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call the number on the back of your Identification Card for contact information.

Notice of Appeal Determination

BCBSTX will notify the party filing the appeal, you, and, if a clinical appeal, any dental care 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. The reasons for the determination;
2. A reference to the benefit Plan provisions on which the determination is based;
3. Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, dental care;
4. Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used'
5. Upon request, treatment codes with their meanings are also available;
6. An explanation of the BCBSTX external review processes (and how to initiate an external review) and a statement of your rights, if any;
7. The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for benefits;
8. Any internal rule, guideline, protocol, or other similar criterion relied on in the
9. determination, and a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
10. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request; and

11. Contact information for applicable office of health insurance consumer assistance or ombudsman.

If BCBSTX denies your appeal, in whole or in part, or you do not receive a timely decision, you have the right to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the **How To Appeal A Final Internal Adverse Determination** to an Independent Review Organization (IRO) section below.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization

An Adverse Determination means a determination by BCBSTX or its designated utilization review organization that a dental care service that is a covered service has been reviewed and, based upon the information provided, is determined to be Experimental/ Investigational, or does not meet BCBSTX's requirements for Dental Necessity or appropriateness, and the requested service or payment for the service is therefore denied or reduced.

A Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by BCBSTX at the completion of BCBSTX's internal review/appeal process.

This procedure (not part of the complaint process) pertains only to appeals of Adverse Determinations.

Any party whose appeal of an Adverse Determination is denied by BCBSTX may seek review of the decision by an IRO. At the time the appeal is denied, BCBSTX will provide you, your designated representative, or your Provider of record, information on how to appeal the denial, including the approved form, which you, your designated representative, or your Provider of record must complete.

1. BCBSTX will submit dental records, names of Providers and any documentation pertinent to the decision of the IRO.
2. BCBSTX will comply with the decision by the IRO.
3. BCBSTX will pay for the independent review. Upon request and free of charge, you or your designee may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim or appeal, including:
    a. Information relied upon to make the decision;
    b. Information submitted, considered, or generated in the course of making the decision, whether or not it was relied upon to make the decision;
    c. Descriptions of the administrative process and safeguards used to make the decision;
    d. Records of any independent reviews conducted by BCBSTX;
    e. Dental judgments, including whether a particular service is Experimental/
    f. Investigational or not Dentally Necessary or appropriate; and Expert advice and consultation obtained by BCBSTX in connection with the denied claim, whether or not the advice was relied upon to make the decision.

The appeal process does not prohibit you from pursuing other appropriate remedies, including: injunctive relief, a declaratory judgment, or other relief available under law.

If you are not satisfied with the outcome of an appeal that has been denied on something other than Dental Necessity or Experimental/Investigational, you may be eligible to file a formal request for final review with TX Health Benefits Pool.

1. You must submit your request within thirty (30) days of receipt of the final appeal determination.
2. Your written request for review should include: (1) your specific request for a final formal review; (2) your name, address, and member ID number; (3) your designated representative's name and address, if applicable; (4)a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the Final Review process at the time we receive your request.
3. Should the TX Health Benefits Pool Executive Director determine that your request for formal review should be elevated to the TX Health Benefits Pool Board of Trustees Executive Committee (Committee) we will schedule a meeting and hear your request. The appealing party may submit additional information and/or appear before the committee. The appealing party will be notified of the date, time, and place the committee will meet at least five (5) days prior to the meeting date.
4. A final decision will be made and sent to the appealing party. The final decision will be in writing and include specific references to the Plan provisions on which the decision was based. There is no further opportunity to request further review after the TX Health Benefits pool Executive Director and/or Board of Trustees Executive Committee provides their final decision.

Interpretation of Employer's Plan Provisions

The operation and administration of the Plan require uniformity regarding the intent of the Plan and the interpretation of the Plan provisions. The Plan Administrator has given BCBSTX the initial authority to establish or construe the terms and conditions of the Plan and the discretion to interpret and determine benefits in accordance with the Plan's provisions.

All powers to be exercised BCBSTX 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.

Legal Actions Against BCBSTX and TX Health Benefits Pool

You must first exhaust the following internal appeals procedures before taking any outside legal action. No lawsuit or action in law or equity may be brought by you or on your behalf prior to the expiration of sixty (60) days after Proof of Loss has been filed in accordance with the requirement of the Plan and no such action will be brought at all unless brought within one year from the expiration of the time within which Proof of Loss is required by the Plan.

Venue for any dispute arising under the terms of the Plan, including but not limited to claims and subrogation disputes or declaratory judgement actions, shall be in Austin, Travis County, Texas.

Subject to the terms and conditions of the Plan, BCBSTX will not pay benefits in excess of the allowable charges, which are incurred for eligible services rendered by a licensed dental provider.

DESCRIPTION OF PLAN BENEFITS

Eligible Dental Expenses

The Plan provides coverage for services and supplies that are considered Dentally Necessary. The benefit percentage to be applied to each category of service is shown on the Schedule of Dental Benefits.

Deductible

Before Benefits are paid, you must meet the appropriate Deductible shown in the Schedule of Dental Benefits. The scheduled Deductibles shall apply individually to each Employee per plan Year. The Deductibles for the Tier Two and Tier Three Dental Services are combined and only a single Deductible applies to these two (2) benefits in any Year.

For plans with Orthodontia coverage, the Tier Four Services for Orthodontic Care have a separate lifetime Deductible.

Benefit Percentage

After the Deductible, if any, has been satisfied, the claims administrator will pay the appropriate percentage of eligible dental expenses shown in your Schedule of Dental Benefits.

Maximum Benefit

BCBSTX will not pay more than the maximum Benefit shown in the Schedule of Dental Benefits.

Benefits

The Plan Benefits are divided into the following sections:

- Tier One Dental Services
- Tier Two Dental Services
- Tier Three Dental Services
- For plans with Orthodontic benefits:
- Tier Four (Orthodontic Care) Services for covered Dependent Children under the age of nineteen (19).

DENTAL LIMITATIONS AND EXCLUSIONS

These general limitations and exclusions apply to all services described in this dental Plan. Dental coverage is limited to services provided by a Dentist or a dental auxiliary, (as defined in the **DEFINITIONS** section) licensed to perform services covered under this dental plan. **Important Information About Your Dental Benefits,** (Dental Procedures Which Are Not Dentally Necessary**)**

In order to provide you with dental care benefits at a reasonable cost, this Plan provides benefits only for those Eligible Dental Expenses that are determined by the Plan to be Dentally Necessary.

No benefits will be provided for procedures which are not Dentally Necessary.

The fact that a Dentist may prescribe, order, recommend, or approve a procedure does not of itself make such a procedure or supply Dentally Necessary.

Care By More Than One Dentist

If you change Dentists in the middle of a particular Course of Treatment, benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of benefits.

Alternate Benefits

In all cases in which there is more than one procedure or Course of Treatment possible to treat a covered dental condition, the benefit will be based upon the least costly procedure or Course of Treatment, as determined by the Plan. If the Participant requests or accepts the more costly service, the Participant is responsible for expenses that exceed the amount covered for the least costly service.

The benefits provided will be limited to the benefit for the standard procedure for dental services, as determined by the Plan, if you and your Dentist decide on:

1. Personalized restorations; or
2. Personalized complete or partial dentures and overdentures; or
3. To employ specialized techniques for dental services rather than standard procedures.

Non-Compliance With Prescribed Care

Any additional treatment and resulting liability which is caused by the lack of a Participant's cooperation with the Dentist or from noncompliance with prescribed dental care will be the responsibility of the Participant.

LIMITATIONS AND EXCLUSIONS

No Benefits Will Be Provided Under This Plan For:

1. Services provided by a non-contracted dentist for plans that do not have an out-of-network benefit. Refer to your Schedule of Dental Benefits.
2. For orthodontic services, unless your plan specifically covers these types of services. Refer to your Schedule of Dental Benefits.
3. Amounts which are in excess of the Allowable Amount, as determined by the Plan.
4. Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to:

a. Bleaching teeth; and
b. Grafts to improve aesthetics.

5. Dental services, radiographic images, or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Benefit Booklet or if resulting from an Accidental Injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Benefit Booklet.
6. Dental services which are performed due to an Accidental Injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an Accidental Injury. Note: The plan will always pay secondary if accident benefits are also paid under a medical plan.
7. Services or supplies for injuries sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority.
8. Services or supplies that are not Dentally Necessary or do not meet accepted standards of dental practice.
9. Services or supplies which are Experimental/ Investigational in nature or not fully approved by a Council of the American Dental Association.
10. Hospital and ancillary charges.
11. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
12. Services or supplies for which "discounts" or waiver of Deductible or Coinsurance Amounts are offered.
13. Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
14. Services or supplies received for behavior management or consultation purposes.
15. For any dental condition, Injury, or disability which (1) was Incurred while working for wage, hire, or monetary gain, or (2) for which benefits could have been available if pursued under benefit for Workers' Compensation whether or not the Employer is a subscriber or non-subscriber in a Workers' Compensation Program, including those individuals who could have been lawfully covered by Workers' Compensation as volunteers. In applying this exclusion, work on the family farm or ranch is not considered an employment arrangement.
16. Any services or supplies for which benefits are, or could upon proper claim be, provided under any laws enacted by the Legislature of any state, or by the Congress of the United States, or any laws, regulations, or established procedures of any county or municipality, except any program which is a state plan for dental assistance (Medicaid); provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for dental expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
17. Charges for nutritional, tobacco, or oral hygiene counseling.
18. Charges for local, state, or territorial taxes on dental services or procedures.
19. Charges for the administration of infection control procedures as required by OSHA, local, state, or federal mandates.
20. Charges for duplicate, temporary, or provisional prosthetic device or other duplicate, temporary, or provisional appliances, or for surgical placement of interim implant body for transitional prosthesis (endosteal implant).
21. Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or radiographic images.
22. For desensitizing medicaments, non- parenteral therapeutic, or other drugs and associated charges used for the delivery of these services.
23. For replacement of any prosthetic appliance, crown, inlay or onlay restoration, fixed bridge, or implant unless:
    a. Required because of accidental bodily Injury which you sustain while covered under the Plan; or
    b. The item is unserviceable, and placement occurred at least five (5) years prior to replacement.
24. Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.
25. Charges for athletic mouth guards.

26. For initial placement of partial or full removable denture or fixed bridge to replace congenitally missing or one or more natural teeth which were extracted prior to the date you became covered. However, this exclusion will not apply if the denture, bridge, or implant also replaces a natural tooth that is extracted while you are covered under the Plan.
27. Replacement of an extracted or missing third molar and/or congenitally missing teeth or surgical treatment of development malformation.
28. Any services, treatments, or supplies included as Eligible Dental Expenses under other hospital, medical, and/or surgical coverage.
29. Case presentations or detailed and extensive treatment planning when billed for separately.
30. For occlusal adjustments if you are not in active periodontal treatment.
31. Endodontic retreatment provided within 12 months of the initial endodontic therapy by the same Dentist.
32. Endodontic endosseous implants, intentional reimplantations, or post removal.
33. Endodontic therapy if you discontinue endodontic treatment.
34. Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological) or for bony impactions covered by another benefit plan.
35. For oral surgery for the following maxillofacial surgical procedures:
    a. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant lesions and growths;
    b. Incision and drainage of facial cellulitis; and
    c. Surgical procedures involving salivary glands and ducts and non- dental related procedures of the accessory sinuses.
36. For osseous and soft tissue grafts and tissue regeneration membranes on previous extraction sites.
37. Charges for replacement of stolen, lost, or defective dentures, crowns, or other appliances.
38. Splinting of teeth including double retainers for removable partial dentures and fixed bridgework.
39. Any procedure, service, or appliance for the purpose of altering or maintenance of vertical dimension of occlusion.
40. Any procedure, service, or appliance provided primarily for cosmetic purposes. Facings, repairs to facings, or replacement of facings on crowns or bridge units on molar teeth shall be considered cosmetic.
41. For services requiring specialized construction where alternate benefits are available, including but not limited to coping, precision, or semi-precision.
42. Gold foil restorations.
43. Tests and oral pathology procedures, or for re- evaluations.
44. The replacement of a defective crown.
45. For services or supplies provided for personal comfort and not necessary for Treatment of a dental condition.
46. For drugs and medicines lawfully obtainable without a physician’s prescription (even if prescribed by a dentist).
47. For services rendered to you by any of the following relatives:
    a. Spouse;
    b. Parent(s), stepparents, or parent(s)- in- law;
    c. Child(ren);
    d. Brother(s) or brother(s)-in-law;
    e. Sister(s) or sister(s)-in-law;
    f. Grandparent(s) or grandparent(s)- in- law;
    g. Grandchild(ren) or grandchild(ren)- in- law; or
    h. Aunt(s) or uncle(s) or aunt(s)- or uncle(s)-in-law.
48. For Treatment of any Injury or illness sustained while you are not covered under the Plan.
49. For orthognathic surgery.
50. For application of antimicrobial agents.

51. For office visits on the same day a service is performed.
52. For procedures not completed.
53. For services which do not have a favorable prognosis.
54. For photos, bite analysis or registration; home preventive supplies or devices.
55. For cone beam craniofacial data capture including two- and three-dimensional image reconstruction.
56. For claims submitted by the Employee or provider after the Filing Deadline.
57. For services associated with the completion of risk assessments.
58. For charges Incurred as a result of travel outside of the U.S. or its territories specifically to receive dental Treatment, unless otherwise specifically covered under the Plan.
59. For diagnostic casts.
60. For services associated with dental case management.
61. For consultations with healthcare professionals.
62. For charges relating to tele-dentistry
63. For any services not listed as a covered dental procedure.
64. Additional Exclusions for plans with Orthodontic Care Services:
65. Surgical placement of temporary anchorage devices.

DEFINITIONS

The Definitions Used in This Benefit Booklet Apply To All Coverage Unless Otherwise Indicated.

Accidental Injury
Accidental bodily injury resulting directly and independently of all other causes, in initial necessary care provided by a Dentist or dental provider.

Actively-At-Work Employee *
Continued eligibility for benefits participation requires an Employee to be actively at work and paid by an employer for at least twenty (20) hours per week or more as defined by said Employer. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on leave by accessing the following and provided that Contributions to the Plan for such Employee continue to be paid on a timely basis:

- regular accrued vacation;
- regular accrued sick;
- regular accrued paid time off; and/or
- paid/unpaid Family Medical Leave Act of 1993 (FMLA); or
- short-term disability leave up to 12 weeks,

For the purpose of this definition, an employee accessing the following leave, which is outside of FMLA, is not considered as being temporarily absent on leave:

- sick leave pool;
- unpaid approved leave;
- catastrophic leave;
- emergency leave; or
- long term disability under any circumstances

Employees that do not meet the definition of an Actively- At-Work Employee in the Plan booklet are not eligible for medical benefits. If both the employer and the employee are eligible, the employee may select to continue their health benefits through a COBRA election. If an employer does not notify TX Health Benefits Pool of the change of employee's work condition, and TX Health Benefits Pool subsequently determines the employee was not eligible for coverage, such coverage will be terminated as of the date of the loss of eligibility. A notification failure could negatively impact the employee as the ability to select COBRA or other forms of insurance. The employer will be responsible for any expense incurred by the Pool for an individual who is not eligible for coverage

Allowable Amount
The allowable amount is the maximum amount determined by BCBSTX to be eligible for consideration of payment for a particular service, supply, or procedure.

1. For multiple surgical procedures performed in the same operative area – The Allowable Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Amount plus an additional Allowable Amount for covered supplies or services.
2. When a less expensive professionally acceptable service, supply, or procedure is available – The Allowable Amount will be based upon the least expensive services. This is not a determination of Dental Necessity, but merely a contractual benefit allowance.

Amendment
A formal document adopted by the Board of Trustees changing the provisions of the Plan. Amendments apply to all Employees, including those persons who are covered before the Amendment becomes effective, unless otherwise specified.

Approval By a Federal Agency
The treatment, procedure, facility, equipment, drug, device, or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient.

Benefit
The amount payable by the Plan for Eligible Benefits.

Board Of Trustees
The Board of Trustees is our governing body as established by Section 172 of the Local Government Code.

Calendar Year
The period commencing each January 1 and ending on the next succeeding December 31, inclusive.

Child
The term "Child" means:

1. Your natural Child who is under twenty-six (26) years of age;
2. Your legally adopted Child (including a Child placed with you for adoption) who is under twenty-six (26) years of age;
3. Your stepchild who is under twenty-six (26) years of age;
4. Your foster Child placed in your care by the State, who is under twenty-six (26) years of age;
5. A Child under twenty-six (26) years of age for whom you or your Spouse is legal guardian or conservator pursuant to a valid court order;
6. Your Child under twenty-six (26) years of age for whom a divorce decree or court order requires you or your Spouse to provide healthcare coverage for the Child; or
7. Your Child age twenty-six (26) or older, provided the Child is totally disabled or incapacitated,

Clean Claim
A "Clean Claim" is one that can be processed in accordance with the terms of this document. Without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment. As set forth in this document, and only as permitted by this document. from being. Made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Coinsurance
The percentage of costs of covered healthcare services you pay (20%, for example) after you have paid your Deductible.

Contracting Dentist
A Dentist who has entered into a written agreement with BCBSTX to participate as a BlueCare dental Provider.

Contribution
The amount payable by the Employer, the amount payable by the Employee, or the amount payable by the Employer and Employee jointly for participation in the Eligible Benefits of the Plan.

Coordination Of Benefits
A provision establishing an order in which plans pay their claims and permitting secondary plans to reduce their Benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Course Of Treatment
Any number of dental procedures or treatments court performed by a Dentist in a planned series resulting from a dental examination concurrently revealing the need for such procedures or treatments.

Court Order
A direction issued by a court or a judge requiring a Participant to do or not do something. A Court Order may also include an administrative order.

Deductible
The dollar amount of Eligible Dental Expenses that must be incurred by a Participant before benefits under the Plan will be available.

Dentally Necessary or Dental Necessity
Those services, supplies, or appliances covered under the Plan which are:

1. Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the dental condition or injury; and
2. Provided in accordance with and are consistent with generally accepted standards of dental practice in the United States; and
3. Not primarily for the convenience of the Participant or Dentist; and
4. The most economical supplies, appliances, or levels of dental service that are appropriate for the safe and effective treatment of the Participant.

BCBSTX shall determine whether a service, supply, or appliance is Dentally Necessary and will consider the views of the state and national health communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Dentist may have prescribed treatment, such treatment may not be Dentally Necessary within this definition.

Dentist
A person, when acting within the scope of their license, who is a Doctor of Dentistry (D.D.S. or D.M.D. degree).

Dependent
The Spouse or Child of an Employee who is eligible for Benefits under the Plan. A Spouse or Child who does not meet the definition of Spouse or Child in this benefit booklet is not eligible for dental Benefits. We may request written proof of the eligibility of any Child and/or Spouse. For example, we may request a copy of a Child's birth certificate or a copy of a divorce decree. These requests are to verify eligibility and to determine if the Plan is primary or secondary.

Effective Date of Coverage
The commencement date of coverage under this Plan as shown on the records of BCBSTX

Eligible Dental Expenses
The Reasonable and Customary fees charged for dental service and supplies covered by the Plan and that are generally furnished for cases of comparable nature and severity in the geographical area where Incurred. Any agreement as to fees or charges made between the individual and the doctor shall not bind the Plan in determining its liability with respect to expenses Incurred. Expenses are Incurred on the date which the service or supply is rendered or obtained. The Employee also must have an obligation to pay the expense.

Employee
A general term that includes, but is not limited to, Actively- At- Work Employees, elected officials, and pre-sixty-five Retirees of Pool Members who are eligible and/or have enrolled in the Plan. For the purpose of this definition, elected officials and employees of affiliated service contractors and economic development corporations are defined as an employee.

Employer
An eligible entity under Section 172 of the Local Government Code that is a member of TX Health Benefits Pool.

Enroll
To make written application for coverage on the prescribed forms or through an online enrollment system. Enrollment is not completed until accepted by the Employer and received by us within required timelines.

EOB
An Explanation of Benefits.

Exclusions
Those charges for which Benefits are not provided. Such charges are listed in "Limitations and Exclusions."

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

Filing Deadline
An In-Network provider is required to file a claim according to their BCBSTX provider contract. If a claim is not filed in a timely manner per the terms of their contract, the claim will be denied, and the patient will not be responsible for any ineligible charges. For Out-of-Network providers, the Plan's Filing Deadline is twelve (12) months from the date the expense was Incurred.

An exception may be granted if it was not reasonably possible, as determined by us, to furnish the information within the Filing Deadlines, or within ninety (90) days after a non-compensable claim decision is made by the Employer's Workers' Compensation carrier or by the Workers' Compensation Division of the Texas Department of Insurance.

The Filing Deadline is the latest date a claim may be received by us to be considered eligible for payment.

Health Insurance Marketplace
Health insurance market plan through the Affordable Care Act's Health Insurance Marketplace www.HealthCare.gov.

HIPAA
Federal law referred to as the Health Insurance Portability and Accountability Act of 1996. HIPAA went into effect for most group health plans on the anniversary that occurred on or after July 1, 1997. HIPAA provides individuals certain rights and protections relating to healthcare coverage.

Identification Card
The card issued to the Employee by the Claim Administrator indicating pertinent information applicable to his coverage.

Incapacitated Child
A Dependent Child age twenty-six (26) or older who is mentally or physically incapable of supporting themself and is primarily dependent upon you for financial support.

We may require satisfactory proof of the continued incapacity documented as a disability by the Social Security Administration (SSA). We may have a Physician examine the Child or may request proof to confirm the incapacity, but not more often than once a year. If you fail to submit proof when reasonably required or refuse to allow us to have the Child examined, then coverage for the Child will terminate.

Incurred
The date on which a service is rendered or a supply is obtained.

In-Network
Identified Dentists and Other Providers, Hospitals, and other facilities that have entered into agreements with BCBSTX (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement

In-Network Benefits
The benefits available under the Plan for services and supplies that are provided by a Network Provider.

Limitations And Exclusions
1. Coverage is excluded for services that are solely educational or vocational in nature or otherwise paid under state or federal law for purely educational services. A service that does not help you to meet or maintain functional goals in a treatment plan within a prescribed timeframe is not a habilitative service.
2. Coverage is excluded when the patient does not meet criteria for coverage as indicated in the Indications for Coverage section above and enrollee specific benefit document.
3. Coverage is excluded if the service is considered by us to be unproven, investigational, or experimental.
4. Coverage is excluded for Confinement, Treatment, services or supplies that are required: a) only by a court of law, or b) only for insurance, travel, employment, and school or camp purposes.
5. Coverage is excluded for services beyond any visit limits specified in the enrollee specific benefit document.

Open Enrollment Period
The thirty (30) or thirty-one (31) day period preceding the next Plan year during which Employees and Dependents may enroll for coverage. Coverage will become effective on the first day of the new plan year.

Orthodontic Services
Movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

Out-Of-Network Benefits
The benefits, if available under the Plan for services and supplies that are provided by an Out-of-Network Provider. Check your Schedule of Dental Benefits to determine if your plan covers out-of-network services.

Out-Of-Network Provider
A Dentist, Hospital, Physician, Behavioral Health Practitioner or Other Provider who has not entered into an agreement with BCBSTX (or other participating Blue Cross and/or Blue Shield Plan) as a managed care Provider

Out-Of-Pocket Amount
The portion of Eligible Benefits which you are responsible to pay.

Participant
An Employee or Dependent(s) covered under this Plan. This Plan may refer to a Participant as "you," or "your."

Plan
The provisions for coverage and payment of Benefits as described in this booklet. This is an incurrence of expense plan that excludes payment for any service of any type Incurred before coverage begins or after coverage ends.

Plan Administrator
TX Health Benefits Pool has been designated to serve as the Plan Administrator.

Plan Anniversary Date
The day, month, and year of the 12-month period following the Plan Effective Date and corresponding date in each year thereafter for as long as the Benefit Booklet is in force.

Plan Effective Date
The date on which coverage for the Employer's Plan begins with the Claim Administrator.

Plan Sponsor
For the purpose of this Plan booklet, TX Health Benefits Pool or Administrative Services Only (ASO) Employer, as applicable.

Preauthorization
The process that determines in advance the Dental Necessity or Experimental/Investigational nature of certain care and services under this Plan. The process for requesting approval in advance for dental Treatment or services.

Prompt Pay
Provider contractual or statutory requirement that assesses penalties for failure for contractual/regulatory timely claim payment.

Proof Of Loss
Written evidence of a claim including:

1. The form on which the claim is made;
2. Bills and statements reflecting services and items furnished to a Participant and amounts charged for those services and items that are covered by the claim; and
3. Correct procedure code(s) for the services and items.

Provider
A physician, Dentist, or any other person, company, or institution furnishing to a Participant, when acting within their scope of their license, an item of service or supply listed as an Eligible Dental Expense.

Responsible Third-Party
Any of the following:

1. A responsible third-party individually;
2. A responsible third-party's insurance company (whether premium funded or self-funded) including, but not limited to, Payments received under the following types of policies: premises, automobile, homeowners, professional, DRAM shop, or any other applicable liability or excess insurance policy;
3. An Employee's own underinsured/uninsured automobile insurance coverage regardless of the source;
4. Any underinsured/uninsured automobile insurance coverage that provides benefits to an Employee;
5. No fault insurance coverage, such as personal injury or medical payments protection regardless of the source;
6. Any award, settlement, or benefit paid under any worker's compensation law, claim or award;
7. Any indemnity agreement or contract;
8. Any other payment designated, delineated, earmarked, or intended to be paid to an Employee as compensation, restitution, remuneration for injuries sustained or Illness suffered as a result of the negligence or liability, including contractual, of any expenses individual or entity; and/or
9. Any source that reimburses, arranges, or pays for the cost of the type of damages covered by the Eligible Benefits of this Plan, including, but not limited to, recovery for the cost of dental expenses.

Retiree
An employee who has ceased active, benefit-eligible employment with the Employer, meets the Employer's minimum length-of-service requirement to qualify as a service retiree and draws all other applicable service retiree benefits. Occupational disability retirement or any type of disability retirement are not considered a service retirement and therefore not entitled to benefits through the Texas Health Benefits Pool, unless otherwise required by law.

Right Of Subrogation
The right of the Pool to recover amounts paid for Benefits on your behalf when a third party may be liable or legally responsible for expenses Incurred by you for an Illness, sickness, or bodily Injury.

Sound Natural Teeth
Teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

Spouse
Individual legally married to you under the laws of any state. We may request written proof of the spousal relationship, such as a copy of the marriage certificate. Proof of a properly filed declaration of informal marriage is required for an informal marriage to be recognized by the Plan.

Standard Dental Treatment
The services or supplies that are in general use in the dental community in the United States, and:

1. Have been demonstrated in peer reviewed literature to have scientifically established dental value for curing or alleviating the condition being treated;
2. Are appropriate for the Provider office in which they were performed; and
3. The Dentist has had the appropriate training and experience to provide the treatment or procedure.

The medical/dental staff of BCBSTX shall determine whether any treatment, procedure, facility, equipment, drug, device,

or supply is Experimental/ Investigational, and will consider the guidelines and practices of Medicare, Medicaid, or other government- financed programs in making its determination.

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

Treatment
Any specific procedure or service which is eligible and used for the cure or improvement of an Illness, disorder, or Injury.

Treatment Plan
A dentist's report that is on a form acceptable to us, and …

1. Lists the dental services your provider proposes to render to you; and
2. Shows charge(s) for each service; and
3. Is accompanied by pre-treatment x-rays or other diagnostic data, which we may require.

GENERAL PROVISIONS

Agent
The Employer is not the agent of the Carrier.

Amendments
The Plan may be amended or changed at any time by agreement between the Employer and TX Health Benefits Pool. If TX Health Benefits Pool makes any material modification in any of the terms of the plan or coverage that would affect the content of the Summary of Dental Benefits (SODB) (a document that summarizes plan benefits, cost sharing, and limitations, as required under the Affordable Care Act), that is not reflected in the most recently provided SODB, and that occurs other than in connection with a renewal or reissuance of coverage, TX Health Benefits Pool will provide notice of the modification to Participants not later than 60 days prior to the date on which the modification will become effective.

Assignment And Payment Of Benefits
If a written assignment of benefits is made by a Participant to a Dentist and the written assignment is delivered to BCBSTX with the claim for benefits, BCBSTX will make any payment directly to the Dentist. Payment to the Dentist discharges BCBSTX responsibility to Participant for any benefits available under the Plan.

Conformity With State Statutes
Laws in some states require that certain benefits or provisions be provided to you if you are a resident of that state when the contract that insured you is not issued in your state. Any provision of this Benefit Booklet which, on its effective date, is in conflict with applicable statutes of the state in which the Employee resides on such date, is hereby amended to conform to: (a) the minimum requirements of such statutes, or (b) the benefits or provisions of this Benefit Booklet to the extent they exceed such minimum requirements.

Disclosure Authorization
If you file a claim for benefits, it will be necessary that you authorize any Dentist, insurance carrier, or other entity to furnish BCBSTX all information and records or copies of records relating to the diagnosis treatment, or care of any individual included under your coverage. If you file claims for benefits, you and your Dependents will be considered to have waived all requirements forbidding the disclosure of this information and records.

Form Or Content Of Plan
No agent or employee of BCBSTX is authorized to change the form or content of this Plan.

Participant/Dentist Relationship
The choice of a Dentist should be made solely by you or your Dependents. BCBSTX does not furnish services or supplies but only makes payment for Eligible Dental Expenses incurred by Participants. BCBSTX is not liable for any act or omission by any Dentist. BCBSTX does not have any responsibility for a Dentist's failure or refusal to provide services or supplies to you or your Dependents. Care and treatment received are subject to the rules and regulations of the Dentist selected and are available only for treatment acceptable to the Dentist.

BCBSTX, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. BCBSTX in no way controls, influences, or participates in the healthcare treatment decisions entered into by said Providers. BCBSTX does not furnish medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients. The Providers, their employees, their agents, their ostensible agents, and/or their representatives do not act on behalf of BCBSTX nor are they employees of BCBSTX.

Refund Of Benefit Payments

If BCBSTX pays benefits for Eligible Dental Expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error, BCBSTX has the right to a refund from the person to or for whom such benefits were paid, any other insurance company, or any other organization. If no refund is received, BCBSTX may deduct any refund due to them from any future benefit payment.

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") applies when you have healthcare coverage through more than one Healthcare Plan. The order of benefit determination rules govern the order in which each Healthcare Plan will pay a claim for benefits. The Healthcare Plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The Healthcare Plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total Allowable Expense.

For purposes of this section only, the following words and phrases have the following meanings:

Allowable Expense
A healthcare expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any Healthcare Plan covering the person for whom claim is made. When a Healthcare Plan (including this Healthcare Plan) provides benefits in the form of services, the reasonable cash value of each service rendered is considered to be both an Allowable Expense and a benefit paid. In addition, any expense that a healthcare provider or Physician by law or in accord with a contractual agreement is prohibited from charging a Participant is not an allowable expense.

Healthcare Plan
Any of the following (including this Healthcare Plan) that provide benefits or services for, or by reason of, medical care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts:

Group, blanket, or franchise accident and health insurance policies, excluding disability income protection coverage; individual and group health maintenance organization evidences of coverage; individual accident and health insurance policies; individual and group preferred provider benefit plans and exclusive provider benefit plans; group insurance contracts, individual insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; medical care components of individual and group long-term care contracts; limited benefit coverage that is not issued to supplement individual or group in force policies; uninsured arrangements of group or group-type coverage; the medical benefits coverage in automobile insurance contracts; and Medicare or other governmental benefits, as permitted by law.

Healthcare Plan does not include: disability income protection coverage; the Texas Health Insurance Pool; workers' compensation insurance coverage; hospital confinement indemnity coverage or other fixed indemnity coverage; specified disease coverage; supplemental benefit coverage; accident only coverage; specified accident coverage; school accident-type coverages that cover students for accidents only, including athletic injuries, either on a "24-hour" or a "to and from school" basis; benefits provided in long- term care insurance contracts for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services; Medicare supplement policies; a state plan under Medicaid; a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan; or other nongovernmental plan; or an individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

Each Contract for coverage is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

BCBSTX has the right to coordinate benefits between this Healthcare Plan and any other Healthcare Plan covering you.

The rules establishing the order of benefit determination between this Plan and any other Healthcare Plan covering you on whose behalf a claim is made are as follows:

1. The benefits of a Healthcare Plan that does not have a coordination of benefits provision shall in all cases be determined before the benefits of this Plan.
2. If according to the rules set forth below in this section the benefits of another Healthcare Plan that contains a provision coordinating its benefits with this Healthcare Plan would be determined before the benefits of this Healthcare Plan have been determined, the benefits of the other Healthcare Plan will be considered before the determination of benefits under this Healthcare Plan.

The order of benefits for your claim relating to paragraphs 1 and 2 above, is determined using the first of the following rules that applies:

1. Nondependent or Dependent. The Healthcare Plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan, and the Healthcare Plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Healthcare Plan covering the person as a dependent and primary to the Healthcare Plan covering the person as other than a dependent, then the order of benefits between the two plans is reversed so that the Healthcare Plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other Healthcare Plan is the primary plan. An example includes a retired employee.
2. Dependent Child Covered Under More Than One Healthcare Plan. Unless there is a court order stating otherwise, Healthcare Plans covering a Dependent child must determine the order of benefits using the following rules that apply.
    a. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
        i. The Healthcare Plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
        ii. If both parents have the same birthday, the Healthcare Plan that has covered the parent the longest is the primary plan.
    b. For a Dependent child whose parents are divorced, separated, or not living together, whether or not they have ever been married:
        i. If a court order states that one of the parents is responsible for the Dependent child's healthcare expenses or healthcare coverage and the Healthcare Plan of that parent has actual knowledge of those terms, that Healthcare Plan is primary. This rule applies to plan years commencing after the Healthcare Plan is given notice of the court decree.
        ii. If a court order states that both parents are responsible for the Dependent child's healthcare expenses or healthcare coverage, the provisions of 2.a. Must determine the order of benefits.
        iii. If a court order states that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses or healthcare coverage of the Dependent child, the provisions of 2.a. Must determine the order of benefits.
        iv. If there is no court order allocating responsibility for the Dependent child's healthcare expenses or healthcare coverage, the order of benefits for the child are as follows:
            I. The Healthcare Plan covering the custodial parent;
            II. The Healthcare Plan covering the spouse of the custodial parent;
            III. The Healthcare Plan covering the noncustodial parent; then
            IV. The Healthcare Plan covering the spouse of the noncustodial parent.

c. For a Dependent child covered under more than one Healthcare Plan of individuals who are not the parents of the child, the provisions of 2.a or 2.b. must determine the order of benefits as if those individuals were the parents of the child.
d. For a Dependent child who has coverage under either or both parents' Healthcare Plans and has his or her own coverage as a Dependent under a spouse's Healthcare Plan, paragraph 5. below applies.
e. In the event the Dependent child's coverage under the spouse's Healthcare Plan began on the same date as the Dependent child's coverage under either or both parents' Healthcare Plans, the order of benefits must be determined by applying the birthday rule in 2.a. to the Dependent child's parent(s) and the Dependent's spouse.

3. Active, Retired, or Laid-off Employee. The Healthcare Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The Healthcare Plan that covers that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the Healthcare Plan that covers the same person as a retired or laid-off employee or as a Dependent of a retired or laid-off employee does not have this rule, and as a result, the Healthcare Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another Healthcare Plan, the Healthcare Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other Healthcare Plan does not have this rule, and as a result, the Healthcare Plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if paragraph 1. above can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Healthcare Plan that has covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan, and the Healthcare Plan that has covered the person the shorter period is the secondary plan.
6. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the Healthcare Plans meeting the definition of Healthcare Plan. In addition, this Healthcare Plan will not pay more than it would have paid had it been the primary plan.

When this Healthcare Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Healthcare Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any Allowable Expense under its Healthcare Plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all Healthcare Plans for the claim equal 100 percent of the total Allowable Expense for that claim. In addition, the secondary plan must credit to its plan deductible (if applicable) any amounts it would have credited to its deductible in the absence of other healthcare coverage.

If a Participant is enrolled in two or more closed panel Healthcare Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel Healthcare Plan, COB must not apply between that Healthcare Plan and other closed panel Healthcare Plans.

For purposes of this provision, BCBSTX may, subject to applicable confidentiality requirements set forth in this Plan, release to or obtain from any insurance company or other organization necessary information under this provision.

If you claim benefits under this Plan, you must furnish all information deemed necessary by Us to implement this provision.

None of the above rules as to coordination of benefits shall delay your health services covered under this Plan.

Whenever payments have been made by BCBSTX with respect to Allowable Expenses in a total amount, at any time, in excess of 100% of the amount of payment necessary at that time to satisfy the intent of this Part, We shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as We shall determine: any person or persons to, or for, or with respect to whom, such payments were made; any insurance company or companies; or any other organization or organizations to which such payments were made.

TERMINATION OF COVERAGE

The Plan excludes payments for any service of any type Incurred after coverage ends. For information concerning your right to continuation of medical coverage, please refer to the COBRA Notice. Once a Retiree moves to COBRA and COBRA terminates, the Retiree is not eligible for our Retiree Benefits.

Coverage under the Plan will terminate for you and/or your Dependent(s) on the earliest of:

1. The end of the month your employment terminates or the end of the month in which we are notified if the notification is received after the 5th of that month and no claims were incurred, (whichever is later);
2. The end of the month in which TX Health Benefits Pool determines you no longer meet the Actively-At-Work Employee definition;
3. The end of the month in which you are no longer eligible for coverage or the end of the month in which we are notified if the notification is received after the 5th of that month and no claims were incurred (whichever is later)
4. The date TX Health Benefits Pool terminates coverage with the Employer;
5. The date your Employer is no longer participating under the Plan;
6. The end of the month in which we were notified that your Dependent becomes enrolled in Medicaid;
7. The end of the month in which your Dependent Child attains age twenty-six (26), unless your Dependent Child is physically or mentally incapacitated;
8. The end of the month in which coverage is voluntarily dropped due to a Qualifying Life Event or at the end of the month in which we are notified (whichever is later) and provided we receive written notice within thirty-one (31) days of the event;
9. The end of the month in which the retiree coverage is voluntarily dropped, or the end of the month in which we are notified if the notification is received after the 5th of that month (whichever is later); or
10. Failure to pay for coverage.

Coverage for a Dependent cannot extend beyond the date coverage for you ends, unless required by Section 615.071, Texas Government Code (Tex. Gov't Code) for survivors of certain Employees as described in Section 615.003, Tex. Gov't Code who are killed in the line of duty. Section 615.075(c), Tex. Gov't Code requires that the survivor must give the Employer notice of election to purchase coverage within one hundred eighty (180) days of the decedent's death.

Dropping Dependent Coverage

The following events may affect Dependent coverage. You are required to notify us within thirty-one (31) days of the below events:

1. Marriage;
2. Birth, adoption, or placement for adoption of a Child;
3. Divorce of the Employee; or
4. Death of the Employee.

You must notify your Employer if you wish to voluntarily drop Dependent coverage. Any drop of a Dependent regardless of whether the coverage is paid for pursuant to pre-tax or post-tax payroll deduction will only be allowed following a Qualifying Event as prescribed by the Internal Revenue Service regulations and on these conditions:

1. Any change in coverage must be consistent with the Qualifying Event; and
2. Once a Dependent has been dropped, he or she cannot be added to the Plan until the next Open Enrollment period or a Qualifying Event occurs. Forms for reporting these changes are available from the Employer.

RESCISSION OF COVERAGE

Rescission of coverage is the cancellation or discontinuance of coverage retroactive to previous date. For example, cancellation of your coverage back to the effective date because you did not meet eligibility requirements of the Plan is a rescission. The Plan will not rescind your or the Employer's coverage except in the case of fraud, or intentional misrepresentation of material fact, or failure to pay for coverage. If the Plan does rescind coverage, we will send a notice to affected individuals at least thirty (30) days prior to rescinding the coverage.

Termination Of the Group

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

Extension Of Benefits

If this Contract terminates (as described in the Employer's Contract), any Participant who is Totally Disabled on the effective date of the termination of the Contract shall be entitled to receive benefits as described in this Benefit Booklet, subject to the benefit limitations and maximums, for the continued treatment of the condition causing the Total Disability. Benefits will be available for the period of the Total Disability or for 90 days following the termination date of the Contract, whichever is less.

However, if your coverage under the Plan is replaced with coverage issued by a Succeeding Carrier which provides substantially equivalent or greater benefits than those provided by this Contract, this extension of benefits for Total Disability is not applicable.

Succeeding Carrier

An insurer that has replaced the coverage of BCBSTX with its coverage.

Total Disability or Totally Disabled

As applied to:

1. An Employee, the complete inability of the Employee to perform all of the substantial and material duties and functions of their occupation and any other gainful occupation in which the Employee earns substantially the same compensation earned prior to disability; and
2. A covered employee's unmarried child who is not eligible to enroll in Medicaid and is mentally or physically incapacitated at the time they turned age 26. A disabled child must have been enrolled in the TX Health Benefits Pool plan at the time they turned age 26 and is primarily dependent upon the employee for financial support. We require satisfactory proof of the continued incapacity documented as a disability by the Social Security Administration (SSA). In addition, we may have an independent physician examine the dependent or may request proof to confirm the incapacity, but not more often than once a year. If the employee fails to submit proof when requested or refuses to have the dependent examined at our request, then coverage of the dependent will terminate.
3. TX Health Benefits Pool must be notified no later than 31 days from the date the child turns 26.

THIRD PARTY LIABILITY

This section, "Third Party Liability", applies if you are injured in an accident or become ill through the act or omission of another person, company, or business and recover money from any source. "Payments" as used in this section shall mean the proceeds of any payment, settlement, judgement, or other remuneration paid by any person or entity other than under the Plan. "Responsible Third Party" as used in this section shall mean any person who is alleged to have caused or contributed in any way to causing the harm for which recovery of damages is sought.

Right Of Subrogation
If the Plan has paid eligible Benefits on your behalf, for expenses related to an Illness or Injury caused by an act or omission of a Responsible Third Party, and you receive Payments from the Responsible Third Party related to that Illness or Injury, the Plan is subrogated to all of your rights of recovery, meaning the Plan must be paid back 100% of what it paid on your behalf for the related medical expenses.

Right Of Recovery
If the Plan provides a Benefit for an Employee that exceeds the amount that should have been paid, the Plan may require that the overpayment be returned when requested or reduce a future Benefit payment for you or your Dependent by the amount of the overpayment. In short, if we paid when we shouldn't have, we have the right to be paid back.

Assignment
If we have paid healthcare expenses related to Employee's Illness or Injury caused by a Responsible Third Party, the Employee's claim against that Responsible Third Party is assigned to us. No Employee may assign, waive, compromise, or settle any rights or causes of action, without our written consent.

Reimbursement
We have the right to be reimbursed for the Eligible Benefits provided to an Employee. If an Employee does not reimburse us from the Payments, we are entitled to reduce current or future Eligible Benefits payable to or on behalf of that Employee until we are fully reimbursed.

Plan's Actions
To protect our interest, we may, among other things: place a lien on a Responsible Third Party or Employee; file a lawsuit on our own or on an Employee's behalf; and/ or cease payment for Eligible Benefits. An Employee's failure to cooperate with the Plan is considered a violation of the Plan. We have the right to: terminate Eligible Benefits, deny future Eligible Benefits, take legal action against an Employee, and/or set off from any future Eligible Benefits. You agree to include the Plan's name as a co-payee on all Payments from Responsible Parties. The fact that we do not assert or invoke these rights until after your settlement or other disposition of a dispute, or you have received Payments as full or partial satisfaction of your losses, shall not relieve you of your obligation to reimburse us in full.

Obligations Of the Employee To The Plan
If you may have a claim against a third party (including any insurance company) as a result of Illness or Injury, you must:

1. Advise us immediately;
2. Fill out and submit an Accident/Injury Questionnaire and fully cooperate with us to provide information regarding your Illness or Injury (including anticipated future Treatment related to the Injury/Illness);
3. Produce all documentation requested, including medical authorizations, correspondence, demands, reports, and insurance adjuster information, non- privileged litigation documents, and/or any other documentation provided to or received from Responsible Third Parties;

4. Fully cooperate with the Plan in the prosecution of a claim;
5. Agree on behalf of yourself and on behalf of any minor Children to allow us to obtain and share your medical information, necessary to investigate, pursue, sue, compromise, and/or settle the above-described claims;
6. Obtain consent of the Plan before settling any claim or suit, including relating to any non- medical elements of damages, or releasing any party from liability for our payment of medical expenses resulting from your Injury or Illness; and
7. Hold any Payment you receive as a result of your Injury or Illness from any Responsible Third Party in trust for our benefit until we have been repaid.

Nothing in these provisions requires us to pursue your claim against any Responsible Third Party.

Miscellaneous

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein. The Plan's rights of subrogation, lien, recovery, assignment, or reimbursement as set forth herein will not be affected, reduced, or eliminated by the "made whole doctrine" and/or any other equitable doctrine or law which requires that the Employee be "made whole" before the Plan is reimbursed. The Plan will not be responsible for any expenses, fees, costs, or other monies incurred by the attorney for the Employee and/or their beneficiaries. In the event that any section of these provisions is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of the Plan. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the plan. The rights expressed in this document in favor of the Plan are cumulative and do not exclude any other rights or remedies available at law or in equity to the Plan or anyone connected with the Plan.

Wrongful Death/Survivorship Claims

In the event that the Employee dies as a result of their Injuries and a wrongful death or survivorship claim is asserted, the Employee's obligations become the obligations of the Employee's wrongful death beneficiaries, heirs, and estate.

Non-Exclusive Rights

By Enrolling in the Plan, you agree to abide by the provisions in one (1) through nine (9) following this paragraph. We may suspend payment of claims for the Injury or Illness based on the amount of the claim, indication of other insurance, indication there may be another source to pay for the medical services required as a result of the Injury or Illness, or evidence that the claim may not be covered because it is work-related.

As an additional assurance, payment of the claim(s), and future claims relating to the Injury or Illness will only resume if you:

1. Provide any and all information requested by us;
2. Agree in writing not to settle damages whether by legal action, settlement, or otherwise until after consulting with us to determine the full and potential medical charges;
3. Agree that should you settle for damages as a result of an Injury/Illness with a Responsible Third Party, prior to securing such written permission, we are relieved of any liability for medical Benefits now or in the future resulting from the Injury/Illness;
4. Agree that we may provide any medical bills or payment information related to the Injury/Illness to your attorney, any insurer, or any other person who will be reimbursing us for medical Benefits;
5. Agree in writing to reimburse us immediately upon collection of damages whether by legal action, settlement, or otherwise including, but not limited to, uninsured motorist, underinsured motorist, no- fault, personal injury protection, or medical payments coverage that is in the name of, paid for, or payable by you or a non-immediate family member;
6. Agree in writing that venue for all subrogation disputes shall be in Travis County, Texas;

7. Agree in writing to provide us with a copy of any settlement agreement relating to this Injury/Illness if requested;
8. Agree to cooperate fully with us in asserting our rights. This means you must supply us with all information and sign and return all documents reasonably necessary to carry out our right to recover from the Responsible Third Party any Benefits paid under the Plan which are subject to this provision; and
9. Agree in writing to all provisions of the Plan.

Automobile/Homeowners Liability And/or Medical Payments Insurance Benefits

Benefits payable under the Plan may be adjusted by us for any insurance benefits available for medical benefits, including no-fault, medical payments, personal injury protection, or uninsured motorist coverage if the coverage for such medical benefits is in the name of, paid for, or payable by a non-immediate family member whether or not any party has admitted liability.

REQUIRED NOTICES

HIPAA Notice Of Privacy Practices For Protected Health Information (Phi)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

TX Health Benefits Pool is required by law to keep your health information private and to notify you if TX Health Benefits Pool, or one of its business associates, breaches the privacy or security of your unsecured, identifiable health information. This notice tells you about TX Health Benefits Pool's legal duties connected to your health information. It also tells you how TX Health Benefits Pool protects the privacy of your health information. As your group health plan, TX Health Benefits Pool must use and share your health information to pay benefits to you and your healthcare providers. TX Health Benefits Pool has physical, electronic, and procedural safeguards that protect your health information from inappropriate or unnecessary use or sharing.

Is All My Health Information Protected?

Your individually identifiable health information that TX Health Benefits Pool transmits or maintains in writing, electronically, orally, or by any other means is protected. This includes information that TX Health Benefits Pool creates or receives and that identifies you and relates to your participation in the health plan, your physical or mental health, your receipt of healthcare services, and payment for your healthcare services.

What Steps Does Tx Health Benefits Pool Take To Protect My Information?

Because TX Health Benefits Pool believes that protecting your health information is of the highest priority, TX Health Benefits Pool takes the following steps to ensure that your health information remains confidential:

1. **Business Associate Agreements** - TX Health Benefits Pool follows the requirements of federal law and makes sure that any TX Health Benefits Pool business associate who receives your personal health information signs a written agreement to protect your health information.
2. **Encryption of Health Data** - TX Health Benefits Pool encrypts your health information that is sent electronically (for example, over the Internet) so that no one who is not supposed to can view your health information. To make sure that only the people who need your health information to administer your health plan benefits are able to see it, TX Health Benefits Pool reviews the list of people who are allowed to view your personal health information on a regular basis.
3. **Independent Review** - TX Health Benefits Pool periodically employs an independent security company to review and test TX Health Benefits Pool's security controls to make sure they meet the requirements of federal law. The independent security company provides certified security professionals to conduct the review.
4. **Use of Health Information** - TX Health Benefits Pool's Privacy Officer reviews the use of personal health information by TX Health Benefits Pool to ensure that it complies with both federal law and with TX Health Benefits Pool's own privacy policies.

How Does Tx Health Benefits Pool Use and Share My Health Information?

TX Health Benefits Pool's most common use of health information is for its own Treatment, payment, and healthcare operations. TX Health Benefits Pool also may share your health information with healthcare providers, other health plans, and healthcare clearinghouses for their Treatment, payment, and healthcare operations. (Healthcare clearinghouses are organizations that help with electronic claims.)

TX Health Benefits Pool also may share your health information with a TX Health Benefits Pool business associate if the business associate needs the information to perform Treatment, payment, or healthcare operations on TX Health Benefits

Pool's behalf. For example, if your health plan includes a retail and mail order pharmacy network, TX Health Benefits Pool must share information with the pharmacy network about your eligibility for benefits. Healthcare providers, other health plans, healthcare clearinghouses, and TX Health Benefits Pool business associates are all required to maintain the privacy of any health information they receive from TX Health Benefits Pool. TX Health Benefits Pool uses and shares the smallest amount of your health information that it needs to administer your health plan.

What Is Treatment, Payment, And Healthcare Operations?

- Treatment is the provision, coordination, or management of healthcare and related services. For example, your health information is shared for Treatment when your family doctor refers you to a specialist.
- Payment includes TX Health Benefits Pool activities such as billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review, and notification of healthcare services. For example, TX Health Benefits Pool may tell a doctor if you are covered under a TX Health Benefits Pool plan and what part of the doctor's bill TX Health Benefits Pool will pay.
- Healthcare operations include quality assessment and improvement, reviewing competence or qualifications of healthcare professionals, underwriting, and other activities necessary to create or renew health plans. It also includes disease management, case management, conducting or arranging for medical review, legal services, auditing functions including fraud and abuse compliance programs, business planning and development, business management, and general administrative activities. For example, TX Health Benefits Pool may use information from your claims to contact you about Treatment alternatives or other health-related benefits and services that may be of interest to you. Please note that while TX Health Benefits Pool may use and share your health information for underwriting, TX Health Benefits Pool is prohibited from using or sharing any of your genetic information for underwriting.

How Else Does Tx Health Benefits Pool Share My Health Information?

TX Health Benefits Pool may share your health information, when allowed or required by law, as follows:

- Directly with you or your personal representative. A personal representative is a person who has legal authority to make healthcare decisions for you. In the case of a Child under eighteen (18) years of age, the
- Child's personal representative may be a parent, guardian, or conservator. In the case of an adult who cannot make their own medical decisions, a personal representative may be a person who has a medical power of attorney.
- With the Secretary of the U.S. Department of Health and Human Services to investigate or determine TX Health Benefits Pool's compliance with federal regulations on protecting the privacy and security of health information.
- With your family member, other relative, close personal friend, or other person identified by you who is involved directly in your care. TX Health Benefits Pool will limit the information shared to what is relevant to the person's involvement in your care and, except in the case of an emergency or your incapacity, you will be given an opportunity to agree or to object to the release of your health information.
- For public health activities.
- To report suspected abuse, neglect, or domestic violence to public authorities.
- To a public oversight agency.
- When required for judicial or administrative proceedings.
- When required for law enforcement purposes.
- With organ procurement organizations or other organizations to facilitate organ, eye, or tissue donation or transplantation.
- With a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties required by law.
- With a funeral director when permitted by law and when necessary for the funeral director to carry out their duties with respect to the deceased person.

- To avert a serious threat to health or safety.
- For specialized government functions, as required by law.
- When otherwise required by law.
- Information that has been de-identified. This means that TX Health Benefits Pool has removed all your identifying information and it is reasonable to believe that the organization receiving the information will not be able to identify you from the information it receives.

Can I Keep TX Health Benefits Pool from Using Or Sharing My Health Information For Any Of These Purposes?

You have the right to make a written request that TX Health Benefits Pool not use or share your health information, unless the use or release of information is required by law. However, since TX Health Benefits Pool uses and shares your health information only as necessary to administer your health plan, TX Health Benefits Pool does not have to agree to your request.

Are There Any Other Times When TX Health Benefits Pool May Use Or Share My Health Information?

TX Health Benefits Pool may not use or share your health information for any purpose not included in this notice, unless TX Health Benefits Pool first receives your written authorization. To be valid, your authorization must include: the name of the person or organization releasing your health information; the name of the person or organization receiving your health information; a description of your health information that may be shared; the reason for sharing your health information; and an end date or end event when the authorization will expire. You may revoke or take back any authorization that you make. Your request to revoke your authorization must be in writing and will not apply to any information shared before TX Health Benefits Pool receives your request.

TX Health Benefits Pool must always have your written authorization to:

- Use or share psychotherapy notes, unless TX Health Benefits Pool is using or sharing the psychotherapy notes to defend itself in a legal action or other proceeding brought by you.
- Use or share your identifiable health information for marketing, except for: (1) a face-to-face communication from TX Health Benefits Pool, or one of its business associates, to you; or (2) a promotional gift of nominal value given by TX Health Benefits Pool, or one of its business associates, to you.
- Sell your identifiable health information to a third party.

Will TX Health Benefits Pool Share My Health Information With My Employer?

TX Health Benefits Pool shares summary health information with your employer. Employers need this information to get bids from other health plans or to make decisions to modify, amend, or terminate the TX Health Benefits Pool group health plan. Summary health information summarizes the claims history, claims expenses, or type of claims experienced by the entire group of people covered under a health plan. Summary health information does not include any information that identifies you, such as your name, social security number, or date of birth.

Also, TX Health Benefits Pool shares with your Employer information on whether you are enrolled in TX Health Benefits Pool's group health plan or if you recently added, changed, or dropped coverage.

Can I Find Out If My Health Information Has Been Shared with Anyone?

You may make a written request to TX Health Benefits Pool's Privacy Officer for a list of any disclosures of your health information made by TX Health Benefits Pool during the last six (6) years. The list will not include any disclosures made for Treatment, payment, or healthcare operations; any disclosures made directly to you; any disclosures made based upon your written authorization; or any disclosures reported on a previous list.

Generally, TX Health Benefits Pool will send the list within sixty (60) days of the date TX Health Benefits Pool receives your written request. However, TX Health Benefits Pool is allowed an additional thirty (30) days if TX Health Benefits Pool notifies you, in writing, of the reason for the delay and notifies you of the date by which you can expect the list.

If you request more than one list within a twelve (12) month period, TX Health Benefits Pool may charge you a reasonable, cost-based fee for each additional list.

Can I View My Health Information Maintained by TX Health Benefits Pool?

You may make a written request to inspect, at TX Health Benefits Pool's offices, your enrollment, payment, billing, claims, and case or care management records that TX Health Benefits Pool maintains. You also may request paper copies of your records. If you request paper copies, TX Health Benefits Pool may charge you a reasonable, cost- based fee for the copies.

Requests To View Your Health Information Should Be Made In Writing To:
TX Health Benefits Pool
ATTN: Privacy Officer
PO Box 140526, Austin, Texas 78714-0526

If I Review My Health Information and Find Errors, How Do I Get My Records Corrected?

You may request that TX Health Benefits Pool correct any of your health information that it creates and maintains. All requests for correction must be made to TX Health Benefits Pool's Privacy Officer, must be in writing, and must include a reason for the correction.

Please be aware that TX Health Benefits Pool can correct only the information that it creates. If your request is to correct information that TX Health Benefits Pool did not create, TX Health Benefits Pool will need a statement from the individual or organization that created the information explaining an error was made. For example, if you request a claim be corrected because the diagnosis is incorrect, TX Health Benefits Pool will correct the claim if TX Health Benefits Pool made an error in the data entry of the diagnosis. However, if your healthcare provider submitted the wrong diagnosis to TX Health Benefits Pool, TX Health Benefits Pool cannot correct the claim without a statement from your healthcare provider that the diagnosis is incorrect.

TX Health Benefits Pool has sixty (60) days after it receives your request to respond. If TX Health Benefits Pool is not able to respond, it is allowed one (1) thirty (30) day extension. If TX Health Benefits Pool denies your request, either in part or in whole, TX Health Benefits Pool will send you a written explanation of its denial. You may then submit a written statement disagreeing with TX Health Benefits Pool's denial and have that statement included in any future disclosures of the disputed information.

I'm Covered as A Dependent And Do Not Want Any Of My Health Information Mailed To The Employee's Address. Will You Do That?

If mailing communications to the Employee's address would place you in danger, TX Health Benefits Pool will accommodate your request to receive communications of health information by alternative means or at alternative locations. Your request must be reasonable, must be in writing, must specify an alternative address or other method of contact, and must include a statement that sending communications to the Employee's address would place you in danger.

Please be aware that TX Health Benefits Pool is required to send the Employee any payment for a claim that is not assigned to a healthcare provider, except under certain medical child support orders.

If I Believe My Privacy Rights Have Been Violated, How Do I Make A Complaint?

If you believe your privacy rights have been violated, you may make a complaint to TX Health Benefits Pool.

Write to:
TX Health Benefits Pool ATTN: Privacy Officer
PO Box 140526, Austin, Texas 78714-0526
Or call: (800) 282-5385

Also, you may file a complaint with the U.S. Department of Health and Human Services. TX Health Benefits Pool will not retaliate against you for filing a complaint.

When Are the Privacy Practices Described In This Notice Effective?

This privacy notice has an effective date of September 1, 2013.

Can TX Health Benefits Pool change its privacy practices? TX Health Benefits Pool is required by law to follow the terms of its privacy notice currently in effect. TX Health Benefits Pool reserves the right to change its privacy practices and to apply the changes to any health information TX Health Benefits Pool received or maintained before the effective date of the change. TX Health Benefits Pool will maintain its current privacy notice on its website at txhb.gov. If a revision is made during your plan year, TX Health Benefits Pool will post the revised notice to its website on the date the new notice goes into effect. You will receive a paper copy of the revised privacy notice before the start of your next plan year.

What Happens to My Health Information When I Leave The Plan?

TX Health Benefits Pool is required to maintain your records for at least six (6) years after you leave TX Health Benefits Pool's group health plan. However, TX Health Benefits Pool will continue to maintain the privacy of your health information even after you leave the plan.

How Can I Get a Paper Copy Of This Notice?

To request that TX Health Benefits Pool mail you a paper copy of this notice, call (800) 282-5385.

Who Can I Contact for More Information On My Privacy Rights?

Write To:
TX Health Benefits Pool
ATTN: Privacy Officer
PO Box 140526, Austin, Texas 78714-0526
Or call: (800) 282-5385

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Note: Certain employers may not be affected by **Continuation of Coverage After Termination**

See your Employer or Group Administrator should you have any questions about COBRA. Specifically, an Employer must have normally employed more than twenty (20) employees on a typical business day during the preceding Calendar Year. This refers to the number of full-time and part- time employees employed, not the number of employees covered by a Health Benefit Plan.

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 a 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 under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is Cobra Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed later in this notice. After a Qualifying Event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes enrolled in Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following Qualifying Events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than gross misconduct;
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

If the Plan provides healthcare coverage to retired employees, the following applies: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When Is Cobra Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the employee, in the event of retired employee health coverage, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the Qualifying Event.

You Must Give Notice of Some Qualifying Events For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the Qualifying Event occurs. Contact your employer and/ or COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

How Is Cobra Coverage Provided?

Once the Plan Administrator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare 8 months before the date on which their employment terminates, COBRA continuation coverage for their spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months). Otherwise, when the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18–month period of continuation coverage. Contact your employer and/or the COBRA Administrator for procedures for this notice, including a description of any required information or documentation.

Second Qualifying Event Extension Of 18-Month Period of Continuation Coverage

If your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

Are There Other Coverage Options Besides Cobra Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead Of Cobra Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period1 to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer)

and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit www.medicare.gov/medicare- and-you.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to your Plan Administrator. For more information about your rights including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U. S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www. dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Contact your employer for the name, address, and telephone number of the party responsible for administering your COBRA continuation coverage

NON-DISCRIMINATION NOTICES

English

TX Health Benefits Pool complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TX Health Benefits Pool does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

TX Health Benefits Pool:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
- Qualified interpreters
    - Information written in other languages
    - If you need these services, contact the Civil Rights Coordinator using the contact information below

If you believe that TX Health Benefits Pool has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@txhb.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Arabic

يلتزمTX Health Benefits Pool بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو نوع الجنس. لا يستبعد TML Health Benefits الأشخاص أو يعاملهم على نحو مختلف بسبب النوع أو اللون أو الأصل الوطني أو السن أو الإعاقة أو نوع الجنس.

TX Health Benefits Pool:

- يوفر مساعدات وخدمات مجانية للأشخاص من ذوي الإعاقات للتواصل بصورة فعالة معنا، مثل:
  - مترجمي لغة إشارة مؤهلين
  - معلومات كتابية بتنسيقات أخرى (مطبوعة بأحرف كبيرة، مواد صوتية، تنسيقات إلكترونية متيسرة، وغير ذلك من التنسيقات)
- يوفر خدمات لغوية مجانية للأشخاص الذين لغتهم الأساسية ليست الإنجليزية، مثل:
  - مترجمين مؤهلين
  - معلومات مكتوبة بلغات أخرى

إذا كنت بحاجة لهذه الخدمات، اتصل بـ Civil Rights Coordinator

إذا كنت تعتقد أن TML Health Benefits قد أخفق في توفير تلك الخدمات أو ميز بطريقة أخرى على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس، يمكن أن تتقدم بشكوى إلى: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526، 9190، 1-800-282-5385، TTY 711، 512-719-6539، CRCoordinator@txhb.gov. يمكن أن تتقدم بشكوى شخصيًا أو بالبريد أو بالفاكس أو البريد الإلكتروني. إذا كنت بحاجة للمساعدة في التقدم بشكوى، فإن Civil Rights Coordinator متاح لمساعدتك.

يمكن أيضًا أن تتقدم بشكوى إلكترونيًا لوزارة Department of Health and Human Services (وزارة الخدمات الصحية والبشرية) ، مكتب Office for Civil Rights (مكتب الحقوق المدنية)، من خلال مكتب Office for Civil Rights Complaint Portal، المتوفر على الرابط https://ocrportal.hhs.gov/ocr/portal/lobby.jsf أو بالبريد أو الهاتف على:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-863-1019, 800-537-7697 (رقم هاتف الصم والبكم)

تتوافر نماذج الشكاوى على الرابط http://www.hhs.gov/ocr/office/file/index.html.

Chinese
TX Health Benefits Pool 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人. TX Health Benefits Pool 不因種、膚色、民族血統、年齡、殘障或性別而排斥任何人或以不同的方式對待他們。

TX Health Benefits Pool:

- 向殘障人士免費提供各種援助和服務，以幫助他們與我們進行有效溝通，如：
  - 合格的手語翻譯員
- 以其他格式提供的書面資訊（大號字體、音訊、無障礙電子格式、其他格式）
- 向母語非英語的人員免費提供各種語言服務，如：
  - 合格的翻譯員
  - 以其他語言書寫的資訊

如果您需要此類服務，請聯絡Civil Rights Coordinator
如果您認為 TX Health Benefits Pool 未能提供此類服務或者因種族、膚色、民族血統、年齡、殘障或性別而透過其他方式歧視您，您可以向Civil Rights Coordinator 提交投訴，郵寄地址為Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 電話號碼為 1-800-282-5385 TTY（聽障專線）號碼為 711, 傳真為 512-719-6539, 電子信箱為 CRCoordinator@txhb.gov.您可以親自提交投訴，或者以郵寄、傳真或電郵的方式提交投訴。如果您在提交投訴方面需要幫助，Civil Rights Coordinator 可以幫助您.

您還可以向 U.S. Department of Health and Human Services（美國衛生及公共服務部）的 Office for Civil Rights（民權辦公室）提交民權投訴，透過Office for Civil Rights Complaint Portal 以電子方式投訴：https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. 或者透過郵寄或電話的方式投訴：

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

登入 http://www.hhs.gov/ocr/office/file/index.html 可獲得投訴表格.

French
TX Health Benefits Pool respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap. TX Health Benefits Pool n'exclut et ne traite aucune personne différemment en raison de sa race, sa couleur de peau, son origine nationale, son âge, son sexe ou son handicap.

TX Health Benefits Pool :

- Fournit gratuitement des aides et services aux personnes handicapées afin de permettre une communication efficace avec nous, par exemple :
    - Interprètes qualifiés en langue des signes
- Informations écrites dans d'autres formats (gros caractères, audio, formats électroniques accessibles, autres formats)
- Fournit gratuitement des services linguistiques aux personnes dont la langue principale n'est pas l'anglais, par exemple:
    - Interprètes qualifiés
    - Informations écrites dans d'autres langues

Si vous avez besoin de ces services, contactez Civil Rights Coordinator.

Si vous pensez que TX Health Benefits Pool n'a pas fourni ces services ou a fait preuve d'une autre forme de discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou le handicap, vous pouvez déposer une réclamation auprès de : Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282- 5385, TTY 711, Fax 512-719-6539, CRCoordinator@txhb.gov. Vous pouvez déposer une réclamation en personne ou par courrier, télécopie ou e-mail. Si vous avez besoin d'aide pour déposer une réclamation, Civil Rights Coordinator se tient à votre disposition pour vous y aider.

Vous pouvez également déposer une réclamation concernant vos droits civiques auprès de l'U.S. Department of Health and Human Services (Département de la Santé et des Services Sociaux des États-Unis), Office for Civil Rights (Bureau des Droits Civiques), par voie électronique via l'Office for Civil Rights Complaint Portal, disponible à l'adresse https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, par courrier ou par téléphone à:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Des formulaires de réclamation sont disponibles à l'adresse http://www.hhs.gov/ocr/office/file/index.html

German

TX Health Benefits Pool erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab. TX Health Benefits Pool lehnt den Ausschluss oder die unterschiedliche Behandlung von Menschen aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

TX Health Benefits Pool:

- Bietet kostenlose Hilfe und Dienstleistungen für Menschen mit Behinderung zur effektiven Kommunikation, wie z. B.:
    - Qualifizierte Gebärdensprachen-Dolmetscher
- Schriftliche Informationen in anderen Formaten (große Ausdrucke, Audio, zugängliche elektronische Formate, sonstige Formate)
- Bietet kostenlose Sprachdienste für Menschen, deren Hauptsprache nicht Englisch ist, wie z. B.:
    - Qualifizierte Dolmetscher
    - Schriftliche Informationen in anderen Sprachen
    -

Sollten Sie diese Dienstleistungen benötigen, so wenden Sie sich an Civil Rights Coordinator

Sollten Sie der Ansicht sein, dass TX Health Benefits Pool es versäumte, diese Dienstleistungen anzubieten, oder auf sonstige Weise aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht diskriminierte, so können Sie eine Beschwerde einreichen bei: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512- 719-6539, CRCoordinator@txhb.gov. Sie können eine Beschwerde persönlich oder per Post, Fax oder E-Mail einreichen. Sollten Sie Hilfe beim Einreichen einer Beschwerde benötigen, so steht Ihnen Civil Rights Coordinator gerne zur Verfügung.

Sie können ebenfalls eine Menschenrechtsbeschwerde einreichen bei: Department of Health and Human Services (U.S.-Gesundheitsministerium), Office for Civil Rights (Amt für Bürgerrechte), elektronisch über das Office for Civil Rights Complaint Portal, zugänglich über https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, oder per Post oder telefonisch an:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Beschwerdeformulare sind verfügbar unter http://www.hhs.gov/ocr/office/file/index.html

Gujarati

TX Health Benefits Pool સમવાયી નાગરિક અરિકાિ કાયદા સાથે સુસંગત છે અને જારત, િંગ, િાષ્ટ્ર ીય મૂળ, ઉં મિ,અશક્તતા અથવા ર ંગના આિાિે ભેદભાવ િાખવામાં આવતો નથી. TX Health Benefits Pool જાર ત, િંગ, િાષ્ટ્ર ીય મૂળ, ઉં મિ, અશક્તતા, અથવા ૈિંરગક કાિણે ોકો બાકાત નથી અથવા તેમની સાથે અ ગ વતતન કિવામાં આવતું નથી.

TX Health Benefits Pool:

- અમાિી સાથે અસિકાિક િીતે સંદે શાવ્યવહાિ કિવામાં અક્ષમ જેવા કે અશક્ત ોકો માટે નીચે પ્રમાણેની મફત સહાય અને સેવાઓ પૂિી પાડવામાં આવે છે:
  - ાયકાત િિાવતા સાંકે રતક ભાષાના દુભારષયા
- અન્ય ફોમેટમાં ખાયે માર હતી (મોટી રપ્રન્ટ, ઓરડયો, સુ ભ ઇ ેક્ટટર ોરનક ફોમેટ, અન્ય ફોમેટ)
- જેની પ્રાથરમક ભાષા અંગ્રેજી ન હોય તેવા ોકોને નીચે પ્રમાણેની મફત ભાષા સેવાઓ પૂિી પાડવામાં આવે છેેઃ
  - ાયકાત િિાવતા દુભારષયા
  - અન્ય ભાષાઓમાં ખવામાં આવે ી માર હતી

તમાિે આ સેવાઓની જરૂિ હોય તો, સંપકત કિો Civil Rights Coordinator

જો તમે માનતા હો કે આ સેવાઓ પૂિી પાડવા માટે TX Health Benefits Pool રનષ્ફળ ગયા છે અથવા જાર ત, િંગ, િાષ્ટ્ર ીય મૂળ, ઉં મિ, અશક્તતા અથવા ર ંગના આિાિે અથવા અન્ય પ્રકાિે ભેદભાવ િાખે છે, તો તમે Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@txhb.gov સમક્ષ ફરિયાદ દાખ કિી શકો છો. તમે ફરિયાદ રૂબરૂમાં અથવા મેઇ , ફેક્ટસ, અથવા ઇમેઇ દ્વાિા દાખ કિી શકો છો. તમને ફરિયાદ દાખ કિવામાં મદદ જોઈતી હોય તો Civil Rights Coordinator તમને મદદ કિવા માટે ઉપ બ્ધ છે.

તમેthe U.S. Department of Health and Human Services (િી યુ. એસ. ડીપાટતમેંટ ઓફ હેલ્થ એન્ડ હ્યુમન સવીરસસ), Office for Civil Rights (ઓફીસ ફોિ રસરવ િાઇટસ]ને પણ) https://ocrportal.hhs.gov/ocr/portal/lobby.jsf પિ ઉપ બ્ધ Office for Civil Rights Complaint Portal, માિફતે રવજાણ િીતે અથવા નીચેના સિનામે મેઇ કે ફોન કિી ફરિયાદ નોંિાવી શકો છો

U.S. Department of Health and Human Services
200 Independence Avenue,
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Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

ફરિયાદનું ફોમત અહી ઉપ બ્ધ છે http://www.hhs.gov/ocr/office/file/index.html

Hindi

TX Health Benefits Pool लागू होने योग्य संघीय नागरिक अधिकाि कानून का पालन किता है औि जाधत, िं ग, िाष्ट्र ीय मूल, आयु, धिकलांगता, या धलंग के आिाि पि भेदभाि नहीं किता है। TX Health Benefits Pool जाधत, िं ग, िाष्ट्र ीय मूल, आयु, धिकलांगता, या धलंग के आिाि पि लोगों को बाहि या उनके साथ अलग तिह का बताि नहीं किता है।

TX Health Benefits Pool:
धिकलांग लोगों को हमाि साथ प्रभाि शाली ढंग से संि ाद किने के धलए धनिःशुल्क सहायता औि सेि ाएं प्रदान किता है, जैसे:

- योग्यताप्राप्त सांके धतक भाषा दुभाधषया

अन्य फॉमेट (बडे धप्रंट, ऑधियो, सुलभ इलेक्ट्र ॉधनक फॉमेट, अन्य फॉमेट) में धलखित जानकाि ी
धजन लोगों की प्राथधमक भाषा अंग्रेजी नहीं है उन लोगों को धनिःशुल्क भाषा सेि ाएं प्रदान किता है, जैसे:

- योग्यताप्राप्त दुभाधषया
- अन्य भाषाओं में धलखित जानकाि ी

यधद आपको इन सेि ाओं की आिश्यकता है तो Civil Rights Coordinator से संपका किं

यधद आपको धिश्वास है धक TX Health Benefits Pool ये सेि ाएं प्रदान किने में धिफल िहा है या जाधत, िं ग, िाष्ट्र ीय मूल, आयु, धिकलांगता, या धलंग के आिाि पि धकसी तिह से कोई भेदभाि धकया है तो आप धनम्नधलखित के पास धशकायत दजा किा सकते हैं: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512- 719-6539, CRCoordinator@txhb.gov. आप स्वयं जाकि या िाक, फै क्स, या ईमेल द्वाि ा भी धशकायत दजा किा सकते हैं। यधद आपको धशकायत दजा किाने में सहायता की आिश्यकता है तो Civil Rights Coordinator आपकी सहायता के धलए उपलब्ध है।

आप https://ocrportal.hhs.gov/ocr/portal/lobby.jsf पि उपलब्ध, Office for Civil Rights Complaint Portal के माध्यम से इलेक्ट्र ॉधनक तिीके से, या िाक या फोन द्वाि ा भी U.S. Department of Health and Human Services (यू.एस. धिपाटामेंट ऑफ़ हेल्थ एण्ड ह्यूमन सधिासेज), Office for Civil Rights (ऑधफस फॉि धसधिल िाइट्स) के पास भी एक नागरिक अधिकाि धशकायत दजा किा सकते हैं:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

धशकायत फॉमा http://www.hhs.gov/ocr/office/file/index.html पि उपलब्ध हैं।

Japanese
TX Health Benefits Pool は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害、または性別に基づく差別をいたしません。TX Health Benefits Pool は人種、肌の色、出身国、年齢、障害、または性別を理由として人を排除したり、異なる扱いをいたしません。

TX Health Benefits Pool:

- 効果的にコミュニケーションを図るため、障害のある人に以下の支援やサポートを無料で提供いたします。
    - 資格ある手話通訳者
- その他形式の文字情報（大きな活字、音声信号、手軽な電子形式、その他）
- 英語を母語としない人へ以下の言語サービスを無料で提供いたします。
    - 資格ある通訳者
    - 英語以外の言語で書かれた情報

これらのサービスを必要とされる場合は、Civil Rights Coordinator までご連絡ください。

TX Health Benefits Pool がこれらのサービスの提供を怠ったり、人種、肌の色、出身国、年齢、障害、または性別に基づいた何らかの方法で差別したと思われる場合、こちらまで苦情を申し立てることができます：Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512-719- 6539, CRCoordinator@ txhb.gov. 苦情の申し立ては、直接、または郵便、ファックス、メールで行うことができます。苦情を申し立てるにあたり援助が必要な場合は、Civil Rights Coordinator がお手伝いいたします
.

また、公民権に関する苦情は、U.S. Department of Health and Human Services（保健社会福祉省）の Office for Civil Rights（公民権局）へ、Office for Civil Rights Complaint Portal https://ocrportal.hhs.gov/ocr/portal/lobby.jsfから電子申請するか、以下へ郵便または電話で申し立てることもできます:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

苦情申立書は http://www.hhs.gov/ocr/office/file/index.html よりダウンロードいただけます.

Korean

TX Health Benefits Pool 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다. TX Health Benefits Pool 은(는) 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 누군가를 배제하거나 다른 방식으로 대우하지 않습니다.

TX Health Benefits Pool:

- 장애인들이 저희와 효과적으로 의사소통할 수 있도록 다음과 같은 무료 지원과 서비스를 제공합니다.
  - 자격있는 수화 통역자
- 다른 형식의 서면 정보(큰 활자, 음성, 사용 가능한 전자 형식, 기타 형식)
- 주로 사용하는 언어가 영어가 아닌 이들에게는 다음과 같은 무료 언어 서비스를 제공합니다.
  - 자격있는 통역자
  - 다른 언어로 작성된 서면 정보

이러한 서비스가 필요하시면 Civil Rights Coordinator 에 연락하십시오.

TX Health Benefits Pool 이(가) 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 이러한 서비스를 제공하지 않거나 다른 방식으로 차별했다고 생각하시는 경우 Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282- 5385, TTY 711, Fax 512-719-6539, CRCoordinator@txhb.gov (으)로 연락하여 불만을 제기하실 수 있습니다. 직접 방문하거나 우편, 팩스 또는 이메일로 불만을 제기하실 수 있습니다. 불만 제기와 관련하여 도움이 필요하시면, Civil Rights Coordinator (으)로부터 지원을 받으실 수 있습니다.

또한 공민권 민원을 미국 Department of Health and Human Services (보건복지부), Office for Civil Rights (시민권 사무국)에 https://ocrportal.hhs.gov/ocr/portal/lobby.jsf 에 있는 시민권 사무국 민원 포털을 통해 전자 방식으로 제출하거나 우편이나 전화로 제출할 수 있습니다. 주소 및 연락처는 다음과 같습니다.

U.S. Department of Health and Human Services
200 Independence Avenue,
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Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

민원 양식은 http://www.hhs.gov/ocr/office/file/index.html 에 있습니다.

Lao

TX Health Benefits Pool

ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຣັຖບານກາງທ ່ບ່ັງຄັບໃຊ້

ແລະບ ່ຈ່ຳແນກບຸກຄົນໂດຍອ ງໃສ່ພື້ນຖານດ້ານ ເຊື້ອຊາດ, ສ ຜິວ, ຊາດກ່ຳເນ ດ, ອາຍຸ, ຄວາມ ພິການ, ຫ ື ເພດ. TX Health Benefits Pool ບ ່ຈ່ຳແນກບຸກຄົນ ຫ ື

ປະຕິບັດ ່ພວກເຂົ້າໂດຍແຕກຕ່ າງ ດ້ວຍເຫດຜົນດ້ານ ເຊື້ອຊາດ, ສ ຜິວ, ຊາດກ່ຳເນ ດ, ອາຍຸ, ຄວາມພິການ, ຫ ື ເພດ. TX Health Benefits Pool:

- ໃຫ້ການຊ່ວຍເຫ ືອ ແລະການບ ລິການ ໂດຍບ ່ເສັງຄ່ າ ແກ່ບຸກຄົນທ ່ພິການ ເພື່ອ ໃຫ້ສາມາດສື່ສານກັບພວກເຮົາໄດ້ຢ່ າງມ ປະສິດທິພາບ, ເຊ່ ນ:
  - ນາຍພາສາໃບ້ທ ່ມ ຄຸນສົມບັດເໝາະສົມ
- ຂ ້ມູນທ ່ເປັນລາຍລັກອັກສອນໃນຮູບແບບອື່ ນໆ (ເຊ່ ນ ຕົວພິມໃຫຍ່, ເຫັບບັນທຶກ, ຮູບແບບ ອີເລັກໂຕຣນິກທ ່ເຂົ້ າເຖິງໄດ້, ຮູບແບບອື່ ນໆ)
- ໃຫ້ບ ລິການດ້ານພາສາໂດຍບ ່ເສັງຄ່ າ
- ແກ່ບຸກຄົນທ ່ພາສາຫ ັກຂອງເຂົ້ າເຈ້ົ າບ ່ ແມ່ນພາສາອັງກິດ, ເຊ່ ນ:
  - ນາຍພາສາທ ່ມ ຄຸນສົມບັດເໝາະສົມ
  - ຂ ້ມູນທ ່ເຂຽນໃນພາສາອື່ ນ

ຖ້ າວ່ າ ທ່ານຕ້ ອງການບ ລິການເຫ ່ ານ ້, ຈົ່ ງຕິດຕ ່ Civil Rights Coordinator ຖ້ າວ່ າ ທ່ານເຊື່ ອວ່ າ TX Health Benefits Pool ບ ່ໃຫ້ການບ ລິການເຫ ່ ານ ້ ຫ ື ຈ່ຳແນກໃນທາງອື່ ນ ໂດຍອ ງໃສ່ພື້ນຖານດ້ານເຊື້ ອຊາດ, ສ ຜິວ, ຊາດກ່ຳເນ ດ, ອາຍຸ,

ຄວາມພິການ, ຫ ື ເພດ, ທ່ານ ສາມາດຍື່ນເລື້ ອງຮ້ ອງທຸກກັບ: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800- 282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@txhb.gov.

ທ່ານສາມາດຍື່ນເລື້ ອງຮ້ ອງທຸກດ້ ວຍ ຕົນເອງ ຫ ື ໂດຍທາງຈົດໝາຍ, ແຟກຊ໌, ຫ ື ອ ເມວ. ຖ້ າວ່ າ ທ່ານຕ້ ອງການຄວາມຊ່ ວຍເຫ ືອໃນ ການປະກອບຄ່ ຳຮ້ ອງທຸກ, Civil Rights Coordinator ແມ່ນພ້ ອມຊ່ ວຍເຫ ືອທ່ ານ.

ນອກຈາກນ ້ ທ່ານຍັງສາມາດຮ້ ອງທຸກດ້ ານສິດທິພົນລະເມືອງໄດ້ ກັບທາງ U.S. Department of Health and Human Services (ກະຊວງປະຊາສົງເຄ ຼາະແລະສຸຂະພາບຂອງສະຫະຣັ ຖ), Office for Civil Rights (ຫ ້ອງການ ສິດທິພົນລະເມືອງ), ໂດຍທາງອີເລັກໂຕຣນິກ ຜ່ ານ Office for Civil Rights Complaint Portal, ຊຶ ່ງມ ໃຫ້ທ ່ ເວັບໄຊ https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, ຫ ື ໂດຍທາງໄປສະນ ຫ ື ທາງໂທຣະສັ ບ ທ ່:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building

Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

ຜອມຄ໋າຮ້ອງທຸກ ໃຫ້ທ ່ເວັບໄຊ http://www.hhs.gov/ocr/office/file/index.html

Persian Farsi

TX Health Benefits Poolز قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

TX Health Benefits Poolر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد ایشان را از خدمات محروم نمی کند و با آنها برخورد متفاوتی ندارد.

TX Health Benefits Pool

- برای افرادی که ناتوانی دارند، برای برقرار کردن ارتباط موثر، کمک هایی بطور رایگان فراهم می کند، مانند:
  - مترجمین واجد شرایط زبان اشاره
  - اطلاعات نوشتاری به فرمت های دیگر (چاپ با حروف درشت، صوتی، فرمت های الکترونیک قابل دسترسی ساده، و فرمت های دیگر)
- برای افرادی که زبان اولیه شان انگلیسی نیست خدمات زبانی رایگان ارایه می کند، مانند:
  - مترجمین شفاهی واجد شرایط
  - اطلاعات نوشتاری به زبانهای دیگر

اگر به چنین خدماتی نیاز دارید، با Civil Rights Coordinator تماس بگیرید

اگر معتقدید که h: TXHB نین خدماتی را به شما ارایه نداده و یا اینکه به شکلی دیگر به دلیل نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت درمورد شما تبعیض قایل شده می توانید شکواییه ای به این آدرس ثبت کنید:

Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526,), 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator(txhb.gov

می توانید با مراجعه شخصی، نامه پستی، فکس یا ایمیل شکواییه خود را ثبت نمایید. اگر برای ثبت شکواییه خود به کمک نیاز دارید، Civil Rights Coordinator می تواند به شما کمک کند.

می توانید از طریق U.S. Department of Health and Human Services (وزارت بهداشت و خدمات انسانی آمریکا)، Office for Civil Rights (اداره حمایت از حقوق مدنی)، شکواییه خود را ثبت نمایید. دسترسی الکترونیکی به این اداره از طریق Office for Civil Rights Complaint Portal به آدرس https://ocrportal.hhs.gov/ocr/portal/lobby.jsf یا تماس از طریق ایمیل یا تلفن با آدرس زیر میسر است:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

فرم های مربوطه برای شکواییه در آدرس اینترنتی http://www.hhs.gov/ocr/office/file/index.html موجود است.

Russian

TX Health Benefits Pool соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола. TX Health Benefits Pool не исключает людей и не относится к ним по-разному из-за расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

TX Health Benefits Pool:

- Для эффективного взаимодействия предоставляет безвозмездную помощь и оказывает услуги людям с ограниченными возможностями, а именно:
  - услуги квалифицированных сурдопереводчиков;
- письменную информацию в других форматах (крупный шрифт, аудио формат, доступные электронные форматы, прочие форматы).
- Предоставляет бесплатные услуги перевода людям, для которых английский не является основным языком, а именно:
  - услуги квалифицированных переводчиков;
  - письменную информацию на других языках.

Если вы нуждаетесь в таких услугах, обратитесь к Civil Rights Coordinator

Если вы считаете, что в TX Health Benefits Pool вам не предоставили указанных услуг или иным образом дискриминировали вас по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола, вы можете подать жалобу: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@txhb.gov. Вы можете подать жалобу лично или отправить по почте, факсу или электронной почте. Если вам нужна помощь в подаче жалобы, вам поможет Civil Rights Coordinator.

Вы также можете подать жалобу о нарушении гражданских прав в U.S. Department of Health and Human Services (Министерство здравоохранения и социальных служб США), Office for Civil Rights (Управление по гражданским правам), в электронном виде через Office for Civil Rights Complaint Portal, доступный по ссылке: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, по почте или по телефону:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201 (США)
1-800-368-1019, 800-537-7697 (TDD)

Бланки жалобы доступны по адресу: http://www.hhs.gov/ocr/office/file/index.html

Spanish
TX Health Benefits Pool cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. TX Health Benefits Pool no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

TX Health Benefits Pool:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
    - Intérpretes de lenguaje de señas capacitados.
- Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos).
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
    - Intérpretes capacitados.
    - Información escrita en otros idiomas.

Si necesita recibir estos servicios, comuníquese con Civil Rights Coordinator.

Si considera que TX Health Benefits Pool no le proporcionó estos servicios o lo discriminó de otra manera por motivos de origen étnico, color, nacionalidad, edad, discapacidad o sexo, puede presentar un reclamo a la siguiente persona: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@txhb.gov.
Puede presentar el reclamo en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, Civil Rights Coordinator está a su disposición para brindársela.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Puede obtener los formularios de reclamo en el sitio web http://www.hhs.gov/ocr/office/file/index.html.

Tagalog
Sumusunod ang TX Health Benefits Pool sa mga naaangkop na Pampederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian. Ang TX Health Benefits Pool ay hindi nagtatangi ng mga tao o hindi nagpapakita ng ibang pakikitungo dahil sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Ang TX Health Benefits Pool ay:

- Nagbibigay ng mga libreng tulong at serbisyo sa mga taong may kapansanan upang mahusay silang makipag-ugnayan sa amin, gaya ng:
  - Mga kwalipikadong interpreter ng sign language
- Nakasulat na impormasyon sa iba pang mga format (malaking print, audio, mga naa-access na electronic na format, iba pang mga format)
- Nagbibigay ng mga libreng serbisyo sa wika sa mga taong hindi Ingles ang pangunahing wika, gaya ng:
  - Mga kwalipikadong interpreter
  - Impormasyong nakasulat sa iba pang mga wika

Kung kailangan mo ang mga serbisyong ito, makipag-ugnayan kay Civil Rights Coordinator

Kung naniniwala kang hindi naibigay ng TX Health Benefits Pool ang mga serbisyong ito o nandiskrimina ito sa ibang paraan batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian, maaari kang maghain ng karaingan sa: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@ txhb.gov. Maaari kang maghain ng karaingan nang personal o sa pamamagitan ng koreo, fax o email. Kung kailangan mo ng tulong sa paghahain ng karaingan, narito si Civil Rights Coordinator upang tulungan ka.

Maaari ka ring maghain ng reklamo sa mga karapatang sibil sa U.S. Department of Health and Human Services (Kagawaran ng Mga Serbisyong Pangkalusugan at Pantao ng U.S.), Office for Civil Rights (Tanggapan para sa Mga Karapatang Sibil), sa electronic na paraan sa Office for Civil Rights Complaint Portal, na makikita sa https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o sa pamamagitan ng koreo o telepono sa:

U.S. Department of Health and Human Services
200 Independence Avenue,
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Ang mga form ng reklamo ay makukuha sa http://www.hhs.gov/ocr/office/file/index.html

Urdu

TX Health Benefits Pool قابلِ اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا TXHB ’نسل، رنگ، قومیت، عمر، معذوری یا جنس پر لوگوں کی ممانعت نہیں کرتا اور نہ ہی ان کے باعث ان کے ساتھ مختلف برتاؤ کرتا ہے۔

TX Health Benefits Pool

- معذور افراد کے ہمارے ساتھ موثر ابلاغ کے لیے مفت میں مدد اور خدمات فراہم کرتا ہے، مثلاً:
  - اہل اشاروں کی زبان کے ترجمان
  - دیگر صورتوں میں تحریری معلومات (بڑے پرنٹس، صوتی، قابلِ رسائی برقی تراتیب، دیگر تراتیب)
- وہ لوگ جن کی اولین زبان انگریزی نہیں ہے ان کو مفت زبان کی خدمات فراہم کرتا ہے، مثلاً
  - اہل ترجمان
  - دیگر زبانوں میں تحریر کردہ معلومات

اگر آپ کو ان خدمات کی ضرورت ہو تو رابطہ کریں Civil Rights Coordinator

اگر آپ سمجھے/سمجھتی ہیں کہ TXHB ان خدمات کی فراہمی میں ناکام رہا ہے یا وہ نسل، رنگ، قومیت، عمر، معذوری یا جنس یا کسی دوسری صورت میں امتیاز کرتا ہے تو آپ ان رابطوں پر شکایت درج کرواسکتے ہیں:-800-1 Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526 282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@tmlhb.org۔ آپ اپنی شکایت رُوبرُو یا ڈاک، فیکس یا ای میل کے ذریعے کرواسکتے ہیں۔ اگر آپ کو شکایت کروانے میں مدد درکار ہو تو Civil Rights Coordinator آپ کی مدد کے لیے دستیاب ہے۔

آپ شہری حقوق کی شکایات U.S. Department of Health and Human Services (ریاستہائے متحدہ امریکہ کے محکمہ صحت اور انسانی حقوق کی خدمات)، Office for Civil Rights (شہری حقوق کے دفتر)، https://ocrportal.hhs.gov/ocr/portal/lobby.jsf پر دستیاب کے Office for Civil Rights Complaint Portal کے ذریعے برقی طور پر یا ای میل یا ٹیلی فون پر بھی درج کروا سکتے/سکتی ہیں :

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

1-800-868-1019, 800-537-7697 (TDD)

شکایت کے فارم یہاں پر دستیاب ہیں http://www.hhs.gov/ocr/office/file/index.html۔

Vietnamese

TX Health Benefits Pool tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính. TX Health Benefits Pool không loại trừ mọi người hoặc đối xử với họ khác biệt vì chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

TX Health Benefits Pool:

- Cung cấp dịch vụ hỗ trợ miễn phí cho những người khuyết tật để giao tiếp với chúng tôi có hiệu quả, như:
  - Thông dịch viên ngôn ngữ ký hiệu đủ năng lực
- Thông tin bằng văn bản ở các định dạng khác (chữ in lớn, âm thanh, định dạng điện tử có thể tiếp cận, các định dạng khác)
- Cung cấp miễn phí các dịch vụ ngôn ngữ cho những người có ngôn ngữ chính không phải là tiếng Anh, như:
  - Thông dịch viên đủ năng lực
  - Thông tin được trình bày bằng ngôn ngữ khác

Nếu bạn cần những dịch vụ này, hãy liên hệ Civil Rights Coordinator

Nếu bạn tin rằng TX Health Benefits Pool không cung cấp những dịch vụ này hoặc phân biệt đối xử theo cách khác dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính, bạn có thể nộp đơn khiếu nại với: Civil Rights Coordinator, PO Box 140526, Austin, Texas 78714-0526, 1-800-282-5385, TTY 711, Fax 512-719-6539, CRCoordinator@txhb.gov. Bạn có thể trực tiếp nộp đơn khiếu nại hoặc gửi qua đường bưu điện, chuyển fax, hoặc email. Nếu bạn cần trợ giúp nộp đơn khiếu nại, Civil Rights Coordinator sẵn sàng giúp bạn.

Bạn cũng có thể nộp đơn khiếu nại về dân quyền lên U.S. Department of Health and Human Services (Bộ Y Tế và Dịch Vụ Nhân Sinh Hoa Kỳ), Office for Civil Rights (Văn Phòng Dân Quyền) bằng hình thức điện tử qua Office for Civil Rights Complaint Portal, có trên trang https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, hoặc qua đường bưu điện hoặc bằng điện thoại tại:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Các mẫu khiếu nại có trên trang http://www.hhs.gov/ocr/office/file/index.html

MEMBER RIGHTS AND RESPONSIBILITIES STATEMENT

Membership	
Rights	**Responsibilities**
You have the right to:	You have the responsibility to:
Receive information about the organization, its services, its practitioners and providers and member's rights and responsibilities.	Provide, to the extent possible, information that your health benefits plan and practitioner/provider need, to provide care.
Make recommendations regarding the organization's member rights and responsibilities policy.	

Communication	
Rights	**Responsibilities**
You have the right to:	You have the responsibility to:
Participate with practitioners in making decisions about your healthcare.	Follow the plans and instruction for care you have agreed to with your practitioner
Be treated with respect and recognition of your dignity and your right to privacy.	Understand your health problems and participate in the development of mutually agreed upon treatment goals, to the degree possible.
A candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.	
Voice complaints or appeals about the organization or the care it provides.	

SCHOOL DISTRICT MEMBER ADDENDUM

This Addendum Only Applies to School District Member Groups And Their Employees

Actively At Work
An Actively-At-Work School District Employee is an employee who works ten (10) or more hours per week, provided that the Employer paid contribution is equivalent to the amount for School District Employees who work twenty (20) or more hours per week.

1. Your coverage as a School District Employee upon timely enrollment will begin, on the later of:
2. The date you became an Actively-At-Work Employee; or
3. The date you complete any Waiting Period established by your Employer.

Adding A Newborn Or Newly Adopted Child Addendum
When adding a newborn or newly adopted Child, you must make enrollment changes within thirty-one (31) days. The fact that you have other Dependent Children covered does not automatically extend coverage to a newborn.

Coverage for a newborn child will be automatic for the first thirty-one (31) days following the birth of your newborn child. For coverage to continue beyond this time, you must notify us within thirty-one (31) days of the birth and pay any required contribution within the next billing cycle. Coverage will become effective on the date of birth. If we are notified after that thirty-one (31) day period. You must wait until the next Open Enrollment Period to Enroll the newborn child.