Administered by:

Managed Health Care

CARES Collegiate Assoc. Resources of the SW
Account #066444
Group #066450 - UD 80A Plan

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SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Ma -0liare benefnaDC 0s.

Preexisting4Conditions

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Important Contact Information

Resource	Contact Information	Accessible Hours
Customer Service Helpline	**1-800-521-2227**	**Monday – Friday 8:00 a.m. – 8:00 p.m.**
Website	**www.bcbstx.com**	**24 hours a day 7 days a week**
Medical Prior Authorization Helpline	**1-800-441-9188**	**Monday – Friday 6:00 a.m. – 6:00 p.m.**
Mental Health/Substance Use Disorder Prior Authorization Helpline	**1-800-528-7264**	**24 hours a day 7 days a week**

Customer Service Helpline

The card offers a convenient way of providing important information specific to your coverage including, but not limited to, the following:

- Your Subscriber identification number. This unique identification number is preceded by a three character alpha prefix that identifies Blue Cross and Blue Shield of Texas as your Claim Administrator.
- Your group number. This is the number assigned to identify your Employer's Health Benefit Plan with the Claim Administrator.
- Any Copayment Amounts that may apply to your coverage.

Preexisting Conditions Provision

Benefits for Eligible Expenses incurred for treatment of a preexisting condition will be available immediately with no preexisting condition Waiting Period.

Specialty Care Providers

A wide range of Specialty Care Providers is included in the Network. When you need a specialist's care, In-Network Benefits will be available, but only if you use a Network Provider.

There may be occasions however, when you need the services of an Out-of-Network Provider. This could occur if you have a complex medical problem that cannot be taken care of by a Network Provider.

- If the services you require are not available from Network

UTILIZATION MANAGEMENT

Utilization Management

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, inpatient admission, and length of stay is based on BCBSTX medical policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require .035 Tw [(ces)3 (vl.7 (i)-1.7 (cal)-1.7)-3.7 (-5.1 (y)of)2.6 (s)4 (t)2.)-3.8 (ss2 (O4 i)-1.7

Surgical Procedures:

- Orthognathic surgery; face reconstruction,
- Mastopexy, breast lift,
- Reduction mammoplasty; breast reduction,

Specialty Pharmacy:

- Medical Benefit Uo6/ it, brea(t)2.4qoTj/TT0 (r)2.70 1 Tf10.98TT0 (r)2.70 1 T (PO)TJETQq49.38 7.92 214 8.87it, b (,

of services, or an authorized representative should obtain Prior Authorization by the Plan by calling one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 6:00 a.m. and 6:00 p.m., Central Time, on business days and 9:00 a.m. and 12:00 p.m., Central Time on Saturdays, Sundays and legal holidays. Calls made after these hours will be recorded and returned no later than 24 hours after the call is received. We will follow-up with your Provider's office. After working hours or on weekends, please call the **Medical Prior Authorization Helpline** toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next working day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network

	Urgent Care Claims	Pre-Service Claims	Post-Service Claims	Concurrent Care Claims
What if additional	You must be notified	If an extension is		

additional information that you believe could change the decision, send it to the Claim Administrator and request a review of the decision as described in **Claim Appeal Procedures** below.

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

- The reasons for the determination;
- A reference to the Health Benefit Plan provisions on which the determination is based;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Information sufficient to identify the claim including the date of service, health care provider, claim amount (if applicable), denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of the internal review/appeals and external review processes available to you (and how to initiate an internal

Determination in accordance with the benefits and procedures detailed below and 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 d v e r / (d v e) 4 . 4

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

	Urgent Care Claim	Pre-Service Claim	Post-Service Claim
Deadline by which a claimant will be notified of an appeals decision	As soon as possible taking into account the medical exigencies, but no more than 72 hours after receipt of the request for review. **Note:** The request may be submitted in writing or orally.		

Claim Review Section
Blue Cross and Blue Shield of Texas
P. O. Box 660044
Dallas, Texas 75266-0044

If you need assistance with the appeal process, please call 1-800-676-2583 Tc -0.003 Tw 0.913 03.224

If you have a claim for benefits which is denied or ignored, in whole or in part, and your Health Benefit Plan is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA after exhausting the Plan's claims and appeals procedures.

A Copayment Amount will be required for facility charges for each Hospital outpatient emergency room visit. If admitted to the Hospital as a direct result of the emergency condition or accident, the Copayment Amount will be waived.

The following are exceptions to the Co-Share Stop-Loss Amounts described above:

dn i o i t) r (The are separate Co-Share Stop-Loss Amounts for In-Network Benefits and Out-of-Network Benefits.) s (gcx

Schedule(s) of Coverage. Remember that certain services require Prior Authorization and that any Copayment Amounts, Co-Share Amounts, and Deductibles shown on your Schedule(s) of Coverage will also apply. Refer to the **UTILIZATION MANAGEMENT** section of this Benefit Booklet for more information.

Benefits for Treatment of Complications of Pregnancy

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

Benefits for Maternity Care

Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. A Copayment Amount will be required for the initial office visit for Maternity Care, but will not be required for subsequent visits. Dependent children will be eligible for Maternity Care benefits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan provides coverage for inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for

items for Diabetes Equipment and Diabetes Supplies (for which a Physician or Professional Other Provider has written an order) and Diabetic Management Services/Diabetes Self-Management Training. Such items, when obtained for a Qualified Participant, shall include but not be limited to the following:

1. Diabetes Equipment

   a. Blood glucose monitors (including noninvasive glucose monitors and monitors for the blind);
   b. Insulin pumps (both external and implantable) and associated appurtenances, which include:
      - Insulin infusion devices,
      - Batteries,
      - Skin preparation items,
      - Adhesive supplies,
      - Infusion sets,
      - Insulin cartridges,
      - Durable and disposable devices to assist in the injection of insulin, and
      - Other required disposable supplies; and
   c. Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

2. Diabetes Supplies

   a. Test strips specified for use with a corresponding blood glucose monitor,
   b. Visual reading and urine test strips and tablets for glucose, ketones, and protein,
   c. Lancets and lancet devices,
   d. Insulin and insulin analog preparations,
   e. Injection aids, including devices used to assist with insulin injection and needleless systems,
   f. Biohazard disposable containers,
   g. Insulin syringes,
   h. Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
   i. Glucagon emergency kits.

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

4. As new or improved treatment and monitoring equipment or supplies become available and are approved by the U. S. Food and Drug Administration (FDA), such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Professional Other Provider who issues the written order for the supplies or equipment.

5. Medical-Surgical Expense provided for the nutritional, educational, and psy

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Mandatory Blue Distinction Centers and Blue Distinction Centers+ Specialty Care Product

The Mandatory BDC and BDC+ Specialty Care product requires you to obtain Bariatric services at a Blue Distinction Center and/or Blue Distinction Center+ in order to obtain maximum benefits. If you choose to utilize a Non-Blue Distinction Center and/or Non-Blue Distinction Center+ you will be responsible for 100% of costs associated with any specialty care received at such facility.

For additional information regarding Blue Distinction Centers for specialty care, please contact a Customer Service Representative at the toll-free telephone number shown on your Identification Card or visit the following website: www.bcbs.com/why-bcbs/blue-distinction.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Any Experimental/Investigational services and supplies.
3. Any portion of a charge for a service or supply that is in excess of the Allowable Amount as determined by the Claim Administrator.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are, or could upon proper claim be, provided under any present or future 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, provided, however, that this exclusion shall not be applicable to any coverage held by the Participant for hospitalization and/or medical-surgical expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
6. Any services or supplies

DEFINITIONS

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

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

Acquired Brain

Dependent (Please refer to the CARES Health Plan

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of Home Health.

Identification Card means the card issued to the Employee by the Claim Administrator of the Plan indicating pertinent information applicable to their coverage.

Imaging Center means a Provider that can furnish technical or total services with respect to diagnostic imaging services and is licensed through the Department of State Health Services Certificate of Equipment Registration and/or Department of State Health Services Radioactive Materials License.

Independent Laboratory means a Medicare certified laboratory that prov.6 (ov.6 (ov4hn4 (a)2.3 c,r9 0 Td[l)2.3 (a)4.4 (b (a)2.3

Medical-Surgical Expenses means the Allowable Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Participant, provided such items are:

1. Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Not included as an item of Inpatient Hospital Expense or Extended Care Expense in the Plan.

A service or supply is furnished at the direction of a Physician, Behavioral Health Practitioner or Professional Other Provider if the listed service or supply is:

1. Provided by a person employed by the directing Physician, Behavioral Health Practitioner or Professional Other Provider; and
2. Provided at the o.3 (n t)2.3 (4.787J0202Td).3H (g3 (m)5 (r0(r)4t)Tj-0.00183113.267 (ovi)2.3 (de)4.3 (r)2.7 (;)3754 0 Td( )

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

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

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

Primary Care Copayment Amount means the payment, as expressed in dollars, that must be made by or on behalf of a Participant for each office visit charge you incur when services are rendered by a family practitioner, an obstetrician/gynecologist, [illegible]

Skilled Nursing Facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services and which is:

1. Licensed in accordance with state law (where the state law provides for licensing of such facility); or
2. 0 8dD1.4 (31’ Td( )s 1.4 (6 (ic3.8((e)7 (ed)sz-)-73d),.1)-4dDc)j4 ( )- Td( )TjEMC.0.0 Td( ).7 (3)--ca Td( )TjEMC.0.o-ln2d

GENERAL PROVISIONS

Agent

The Employer and CARES is not the agent of the Claim Administrator.

Amendments

The Plan may be amended or changed at any time by agreement between CARES and the Claim Administrator.

The Claim Administrator's Ownership Interests

The Claim Administrator or its subsidiaries or affiliates may have ownership interests in certain Providers who provide covered services to Participants, and/or vendors or other third parties who provide covered services related to the benefits and requirements of this Plan or provide services to certain Providers.

Assignment and Payment of Benefits

Rights and benefits under the Plan shall not be assignable, either before or after services and supplies are provided.

In the absence of a written agreement with a Provider, the Claim Administrator reserves the right to make benefit payments to the Provider or the Employee, as the Claim Administrator elects. Payment to either party discharges the Plan's responsibility to the Employee or Dependents for benefits available under the Plan.

Claims Liability

BCBSTX, in its role as Claim Administrator, provides administrative claims payment services only and does not

The Claim Administrator, Network Providers, and/or other contracting Providers are independent contractors with respect to each other. The Claim Administrator in no way controls, influences, or participates in the health care treatment decisions entered into by said Providers. The Claim Administrator does not furnish medical, surgical, p3as2J0.0c 0.1c w2p3as3J0.0c 0.1c w2

If you or your Dependent recover money from any person, organization, or insurer for an injury or condition for which the Plan paid benefits, you or your Dependent agree to reimburse the Plan from the recovered money for the amount of benefits paid or provided by the Plan. That means you or your Dependent will pay to the Plan the amount of money recovered by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any

amount of

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2. insurance companies; or
3. Hospitals, Physicians, or Other Providers; or
4. any other person or organization.

Termination of Coverage

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

Continuation of Group Coverage - Federal

COBRA Continuation - Federal

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Participants may have the right to continue coverage after the date coverage ends. Participants will not be eligible for COBRA continuation if the Employer is exempt from the provisions of COBRA.

Please check with your Employer or Human Resources Department to determine if Domestic Partners are eligible for COBRA-like benefits in your Plan. For specific criteria or necessary forms required to establish eligibility for benefit coverage under this Plan, contact your Employer or Human Resources Department.

Minimum Size of Group

The Group 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.

Loss of Coverage

If coverage terminates as the result of termination (other than for gross misconduct) or reduction of employment hours, then the Participant may elect to continue coverage for eighteen (18) months from the date coverage would otherwise cead6A

AMENDMENTS

BENEFIT BOOKLET
NO SURPRISES ACT
AMENDMENT

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

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

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

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

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
   You are pregnant or undergoing a course of treatment for Your pregnancy, or
   You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if You are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies You of the Provider's termination, or any longer period provided by state law. If You are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for

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

“Emergency Services” means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or an Independent Freestanding Emergency Department;
- further medical examination or treatment You receive at a Hospital, regardless of the department of the Hospital, or an Independent Freestanding Emergency Department to evaluate and treat an Emergency Medical Condition until Your condition is stabilized; and
- covered services You receive from a Non-Participating Provider during the same visit after Your Emergency Medical Condition has stabilized unless:
    1. Your Non-Participating Provider determines You can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided You with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

“Non-Participating Provider” means, for purposes of this Amendment only, with respect to a covered item or service, a physician or other health care provider who does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

“Non-Participating Emergency Facility” means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an Independent Freestanding Emergency Department that does not have a contractual relationship with BCBSTX for furnishing such item or service under the Plan to which this Amendment is attached.

“Participating Provider” means, for purposess7r Pn6uads7rs7ds7rvigforT (e)-1 (r)-shing oeg(md51h).ep (r)-s( )]TJ0 Tc 0

NOTICES

NOTICE

Other Blue Cross and Blue Shield

NOTICE

C. Non-Participating Healthcare Providers Outside BCBSTX Service Area

1. In General

   When Covered Services are provided outside of the Plan's service area by non-participating healthcare Providers, the amount(s) you pay for such services will be calculated using the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating healthcare Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

2. Exceptions

   In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion negotiate a payment with such non-participating healthcare Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

   a. the amount calculated using the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area (and described in Section C(a)(1) above); or
   b. The following:

      1. for professional Providers, an amount equal to the greater of the minimum amount required in the methodology described in the Benefit Booklet for non-participating healthcare Providers located inside your service area; or an amount based on publicly available Provider reimbursement data for the same or

FEDNOTICE

NOTICE

ALTHOUGH HEALTH CARE SERVICES MAY BE OR HAVE BEEN PROVIDED TO YOU AT A HEALTH CARE FACILITY THAT IS A MEMBER OF THE PROVIDER NETWORK USED BY YOUR HEALTH BENEFIT PLAN, OTHER PROFESSIONAL SERVICES MAY BE OR HAVE BEEN PROVIDED AT OR THROUGH THE FACILITY BY PHYSICIANS AND OTHER HEALTH CARE PRACTITIONERS WHO ARE NOT MEMBERS OF THAT NETWORK. YOU MAY ID 7 (W)-5.R0.5 (R)-3.5 MOF MI N

NOTICE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

INTRODUCTION

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

The right to COBRA continuation coverage was created by 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.

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

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

Information Provided by your Employer

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

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

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

(c) in the case of the Employee's or Dependent's loss of coverage under Medicaid or CHIP due to loss of eligibility for Medicaid or CHIP or the Employee's or Dependent's eligibility for a premium assistance subsidy under CHIP, the date of the loss of coverage or commencement of eligibility for a premium assistance subsidy, provided that special enrollment is timely requested.

Change in Status

If you have a "change in status," you may be permitted to change your elections under the Plan. A "change in status" includes the following events:

- a significant change in the amount of required contributions;
- addition of a new benefit option under the Plan;
- a significant reduction in a benefit option;
- marriage or divorce;
- birth or adoption (including placement for adoption) of a child, change in child custody, or the addition of stepchildren;
- death of a Dependent;
- a Dependent ceasing to satisfy the definition of "Dependent" under the Plan;
- commencement of employment by your Spouse;
- a change in employment for you or your Spouse due to switching from full-time to part-time employment status;
- the beginning or end of your Spouse's employer-provided insurance coverage because of a change in employment status; or
-

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

Erroneous Claims and Administrative Errors

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

- notification to you of the error, (e)3 63 (c)2.9 bY1 Tc -0.41-4.5 (o)]T 9 ( )10.9 (e)154 (sgr9 (t)-4.7)2.8 (g)1

PPO 80A Prescription Drug Program

If you elected to be covered under the PPO 80A option offered under the Health Care Benefit Program, your prescription drugs will be covered in accordance with the following schedule:

Annual Deductible

How the Prescription (Rx) Drug Program Works

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

Retail Pharmacy Service

Present your identification card, along with your prescription or refill order at any pharmacy in the Express Scripts network and pay the applicable copay. The pharmacy will dispense up to a 30-day supply of the drug to you. Certain drugs are limited to the dosage recommended by the drug manufacturer. Such dosage recommendations may result in less than a 30-day supply. Refer to the section of the SPD below titled "Quantity Restrictions on Covered Medications" for more information.

Please note that you must use a pharmacy within the Express Scripts network for your retail benefits. Most major retail pharmacies (e.g., CVS, Walmart Stores, Inc., Kro.5 (tha)4,8o.5 ( )0.5 ila(o.5 (tha)4,8o.5 (t7-0.003 Tc)2

to have coverage for those prescription drugs or related supplies. The length of the authorization will depend on the diagnosis and prescription drug or related supplies.

If the request for prior authorization is denied, your physician and you will be notified that coverage for the prescription drugs or related supplies is not authorized. If you disagree with a coverage decision, you may appeal that decision in accordance with the Claims Procedures detailed in this Supplement.

If you have questions regarding a specific prior authorization request, call RxBenefits Customer Service at the toll-free number on your combined Medical/Pharmacy identification card.

Here's what occurs when a prescription drug needs a Prior Authorization:

1. When you hand in your prescription, your pharmacist sees a note on the computer system indicating "prior authorization reqund.8 (on d)s 71.9 (n1(td (on if4.6 1(a1.7)-r4.71 ())6.45 r)-73.he)(a spti)1 0.4 A (-

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

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

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

- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA, unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United State Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer reviewed national professional medical journal;

- prescription and non-prescription supplies (such as ostomy supplies), devices and appliances other than "related supplies." The term "related supplies" means diabetic supplies (insulin needles and syringes, lancets, glucose test strips), needles and syringes for injectable drugs covered under the Prescription (Rx) Drug Program, and spacers for use with oral inhalers;

- implantable contraceptive products;

- any fertility drug

- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction,

Quantity Restrictions on Covered Medications

In addition to the Exclusions and Limitations listed above, each prescription order or refill shall be limited as follows:

- Up to a consecutive 30-day supply, at a Retail Pharmacy, unless limited by the drug manufacturer's packaging;
- Up to a consecutive 90-day supply, through ESI's Home Delivery, unless limited by the drug manufacturer's packaging
- Up to a dosage and/or dispensing limit, as determined by ESI Scripts, Inc.; and
- Specialty medications may be dispensed in limited quantities per order or refill and will require a separate copay for each 30-day supply.

EMPLOYEE ASSISTANCE PROGRAM (“EAP”)

ELIGIBILITY

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

BENEFITS

The Employee Assistance Program (“EAP”) is available 24 hours a day, seven days a week, with trained and licensed counselors who can provide confidential advice, counseling and referral services to assist you and the

THE WELLNESS PLAN

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

- Register with Mobile Health and complete an online health risk assessment
- Complete a biometric screening onsite via eHealthScreenings as an alternative to an on-campus screenings. Employees may use their existing health care provider using the PCP/Lab form provided by eHealthScreenings. This form must be completed and submitted to eHealthScreenings by the predetermined deadline to receive the premium incentive or HSA contribution.
- Complete two Mobile Health Challenges or participate in Wondr Health or Livongo

Mobile Health

Mobile Health is The University's wellbeing and engagement platform accessed via the Mobile Health App designed to provide you a targeted experience that considers our health, lifestyle, motivation, and preference allowing you to develop your own sense of holistic wellbeing.

Hypertension

Livongo for Hypertension includes

- Easy remote monitoring via wireless connected blood pressure cuff.
- Mobile app access to track progress, receive personalized content and get notifications or reminders to check your blood pressure.
- Expert Guidance on current medications and 24/7 coaching for nutrition and weight, and more.
- Realistic, personalized lifestyle recommendations to modify behavior and stay on track.

How to Register

- Access www.getlivongo.com/TXHEALTH
- Use registration code: TXHEALTH

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

- Well onTarget Member Wellness Portal – Personalized action plans, along with fitness and nutrition device integration, jump start each employee's journey toward overall wellbeing. Convenient digital self-management programs address a variety of wellness and lifestyle topics, including:
    - Stress
    - Weight loss
    - Tobacco cessation
    - Asthma, diabetes and other chronic conditions
    - Sleep health
    - Financial wellbeing

- Utilization Management – You and your doctor can obtain information about your benefits and easily navigate the health care system to help you maximize your benefits for covered services

- Health Advisor – A care team, led by a health advisor, addresses the physical, mental and emotional aspects of health issues for the most costly and complex cases.1 Members can interact with their health advisor through email, secure messaging or scheduling a callback. Health advisors may also send text message reminders.

- Blue Points – Members can earn points for completing healthy activities like taking a Health Assessment, enrolling in self-management program, joining the Fitness Program or using a fitness tracker. They can then redeem those points for merchandise.

- Targeted Messaging – Automated touch points triggered by missed appointments, tests and prescription refills help engage members across the health spectrum. Personalized reminders emphasize the importance of annual visits, preventive screenings and immunizations. Educational messages encourage members with chronic conditions, such as diabetes and asthma, to take actions to improve their health.

- Women's and Family Health – Comprehensive support for fertility, pregnancy and parenting includes:
    - App-based coaching delivered by Ovia Health®, addressing pregnancy, pregnancy and post-pregnancy wellness. Assessments within each program prompts personalized content and referrals to the high-risk program when necessary.
    - Personal phone support and education from a Blue Cross and Blue Shield of Texas (BCBSTX) maternity specialist for high-risk cases
    - Digital self-management programs through Well onTarget® to help members plan for a healthy pregnancy and baby

Benefits for All Employees

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

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MDLIVE

When youjust can’t get to the doctor

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

When Can I use MDLive?

When

OTHER IMPORTANT INFORMATION

SUBROGATION AND RIGHT OF REIMBURSEMENT

When This Provision Applies (Prescription (Rx) Drug Program Only)

You or your dependent(s) (hereinafter "beneficiary") may incur medical or prescription expenses because of illness or injuries for which benefits are paid by the Plan but which were caused by another party. The beneficiary may therefore have a claim against the party for payment of the medical or prescription expenses incurred. In these instances, the Plan has no duty or obligation to pay claims related to this illness or injury. However, if the Plan chooses to pay benefits, it has both a right of Subrogation and a right of Reimbursement. Each right is separate and the waiver of one right by the Plan shall not be deemed to waive the other right. Under the Plan's right of Subrogation, the Plan is subrogated to all of the rights the beneficiary may have against that other party. This right of Subrogation also applies when a beneficiary has a right to recover under an uninsured or underinsured motorist's plan, homeowner's plan, renter's plan, or any other insurance policy under which the beneficiary is insured. The Plan also retains a right of first lien against any monies received by the beneficiary from the other person. Any monies received by a bersoncic6.1 (r)33.8 (e)0 w

Sponsor shall be entitled to offset the amount of such recovery by the amount of benefits previously paid by

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

In the case of the Claim involving Urgent Care, the following timetable shows the maximum amount of time in which particular events generally must occur:

Event	Time Permitted
Notification to Participant of benefit determination (adverse or not)	72 hours
If there is insufficient information on the Claim, or the Participant ha failed to follow the Plan's procedure for filing a Claim:	
Notification to Participant of deficiency, orally or in writing	24 hours
Response by Participant, orally or in writing	Not less than 48 hours
Benefit determination, orally or in writing	24 hours after receipt of additional information or expiration of Covered Person's time to respond
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours
Review of adverse benefit determination	72 hours

If there is an adverse benefit determination on a Claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the covered person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the covered person by telephone, facsimile, or other similarly expeditious method.

Post-Service Claim

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

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

Event	Time Permitted

- a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
-

The IRO will provide you with a written notification that it has received and accepted your request for external review, and give you the opportunity to submit additional information within 10 business days. The Claims Administrator will provide the IRO any information and documentation it considered in making its adverse benefit determination. If you supply additional information to the IRO, the IRO will forward that information to the Claims Administrator, at which point the Claims Administrator may reconsider its adverse benefit determination.

The IRO will review your claim without giving deference to the Claims Administrator's prior decisions, and will take into account any additional information you have supplied. In addition, in making its determination, the IRO may consider all documents and information provided, including, but not limited to, your medical records, your physician's recommendations, the terms of the Plan, appropriate practice guidelines, and the opinion of the IROs clinical reviewer(s).

The IRO will render its decision within 45 days of its receipt of the request for review and will provide written notification to both you and the Plan. This notification will include (1) a general description of the reason for the request for external review, including sufficient information to identify the claim, (2) the date the IRO received the request for external review and the date of its decision, (3) reference to the evidence or documentation considered in reaching its decision, (4) the reason(s) for its decision, including any evidence based standards that were relied on, (5) a statement that the determination is binding except to the extent other remedies are available under state or federal law, (6) a statement that judicial review may be available, and (7) current contact information for any applicable office of health insurance consumer assistance or ombudsman.

If the decision of the IRO reverses the adverse benefit determination, the Plan will accept the decision and

The IRO will follow the review process described above, and render a decision within 72 hours after it receives the request for review. The IRO will provide a written confirmation of its decision to both you and the Plan with 48 hours thereafter.

You may contact the Claims Administrator at the number in the "General Information" Section of this Summary for more information regarding your external appeal rights and the independent review process.

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

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

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

Please note that, for purposes of COBRA

A health plan cannot penalize, reduce, or limit reimbursement of providers because they provided care under the terms of this law.

FEDERAL MINIMUM MATERNITY BENEFITS

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits or require pre-authorization for a hospital stay in connection with childbirth of less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NON -DISCRIMINATION

Notwithstanding anything in the Plan to the contrary, the Plan may not discriminate against any individual or dependent of that individual with respect to health coverage on the bases of a health factor. Further, the Plan shall not (a) adjust premium contribution amounts based on genetic information, (b) request or require an individual or family member of an individual to undergo a genetic test (except in certain circumstances related to research), or (c) request, require, or purchase genetic information with respect to any individual prior to the individual's enrollment in the Plan or coverage in connection with enrollment in the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

The Plan complies with the requirements of any "Qualified Medical Child Support Order" as defined in Section 609(a)(2)(A) of ERISA. A Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency that:

- provides for child support with respect to your child under a group health plan, or provides for health benefit coverage for your child; and

- is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under the company's health care plan.

YOUR PRIVACY RIGHTS UNDER THE HEALTH

- CARES shall make your PHI available to you for amendment and incorporate any amendment i your PHI (as described below); and

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

Access to PHI

Other Uses of PHI

Any other uses and disclosures of your PHI will be made only with your written authorization. If you provide the Plan authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization.

YOUR RIGHTS UNDER ERISA

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The oi(R)-4. (e)5 (w)5 (h.7 (o4i-3.6 (u(n.) (ng)3.4m)-2.9 (t)10.).mf)-1.2 orthe Pla

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

- is subject to a physical or mental impairment or disability which can be expected to result in death or which has lasted or is expected to last for a continuous period of not less than 12 months; and
- is unable to engage in any substantial gainful activity due to such physical or mental impairment;
- for whom proof of such physical or mental impairment is submitted to the Plan Administrator within the 31 day period following the date the child would otherwise lose Dependent status.

ELIGIBLE RETIREE means each Employee who

- is a Participant in the Plan during the 3 month period immediately prior to retirement from a Member School;
- was actively working on the day prior to retirement;
- is at least 55 years of age and has a minimum of

PLAN IDENTIFYING INFORMATION

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

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

Name of the Plan	Collegiate Association REsource of the Southwest, Inc. Health Plan
Plan Number	501
Plan Sponsor and its IRS Employer Identification Number	Collegiate Association REsource of the Southwest, Inc.