TEXAS ASSOCIATION of COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL

Galveston County

Group #303222 - HDHP Plan

Group #300915 - Base Plan

Group #300915 - Buy-Up Plan

Health Benefits

Waiting period

A waiting period is a set amount of time that must pass from an employee's date of hire to when that employee's health insurance benefits begin.

Employee and Elected Official: 30 days - 1st of the month: Eligible for coverage on the first of the month following 30 days from date of hire.

Example: Hire Date = June 15 + 30 days = July 14, coverage effective August 1

Contact Information

Vendor	Benefit	Phone Number	Website
BlueCross BlueShield of Texas	**Medical** Blue Cross Blue Shield of Texas	855-357-5228	www.bcbstx.com
NAVITUS PHARMACY BENEFITS REINVENTED™	**Prescription** Navitus Health Solutions	866-333-2757	www.navitus.com
MDLIVE	**Telemedicine** Blue Cross Blue Shield of Texas	855-357-5228	www.MDLive.com/BCBSTX
Healthy County Together. Better. Stronger. Texas Association of Counties Health and Employee Benefits Pool	**Wellness Program** TAC Healthy County	800-456-5974	www.mybenefits.county.org

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I.
Online Benefits Portal / Employee Self Service

ONLINE BENEFITS PORTAL: EMPLOYEE SELF-SERVICE (ESS)

Accessing your current health benefits and wellness program resources online should be easy. That's why we created Employee Self-Service (ESS) for **county and district employees**. ESS is one single website with all the links you need. Just one password here gets you access to Blue Cross and Blue Shield of Texas (BCBSTX), Navitus (prescription drugs), Healthy County wellness initiatives and more.

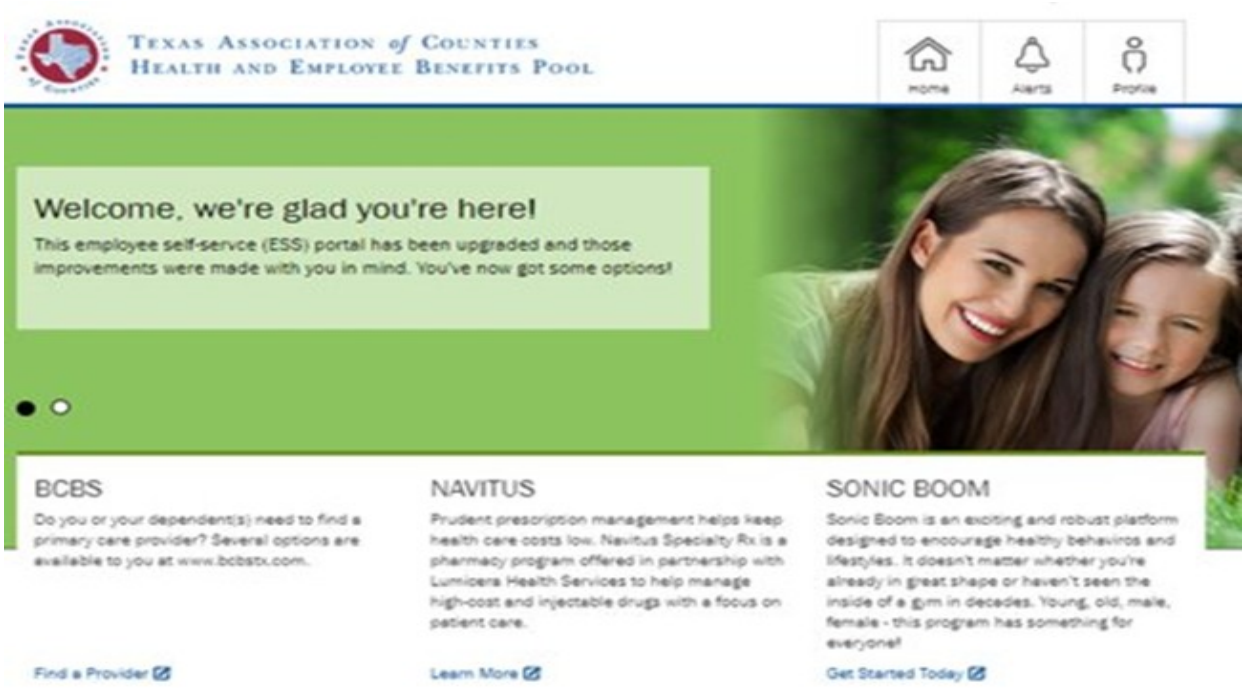
WHERE CAN I ACCESS ESS ONLINE?

Go To: **https://mybenefits.county.org**

Save or bookmark this web address as a favorite so you can reference your benefits and tools with one simple click!

WHAT CAN I DO IN THE EMPLOYEE SELF-SERVICE (ESS) TOOL?

Get Benefits Information	See the benefits available through your employer, including wellness program details, plus links to TCDRS (retirement system) and more.
My County Benefits	Access your current health and prescription coverage* Benefits Summaries and details; find claim forms, order replacement ID cards and more. ** plus Dental, Vision and Life if provided through TAC HEBP*
Review Current Enrollment	Retrieve and review your benefit selections, update your contact information, change Life beneficiary*, and more. ** if Life coverage provided through TAC HEBP*

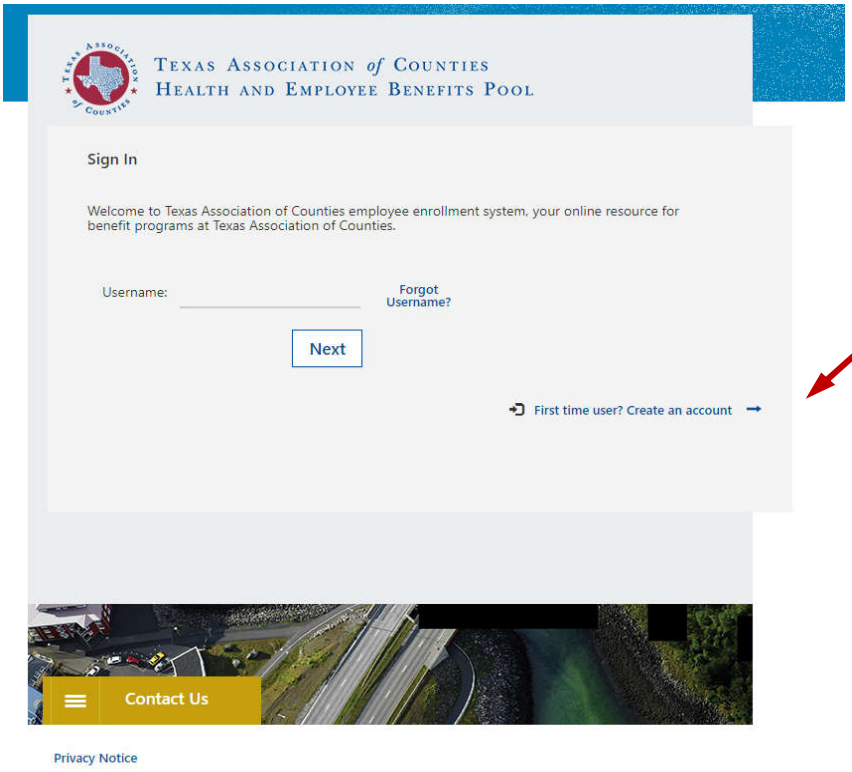


FIRST TIME USER INFORMATION

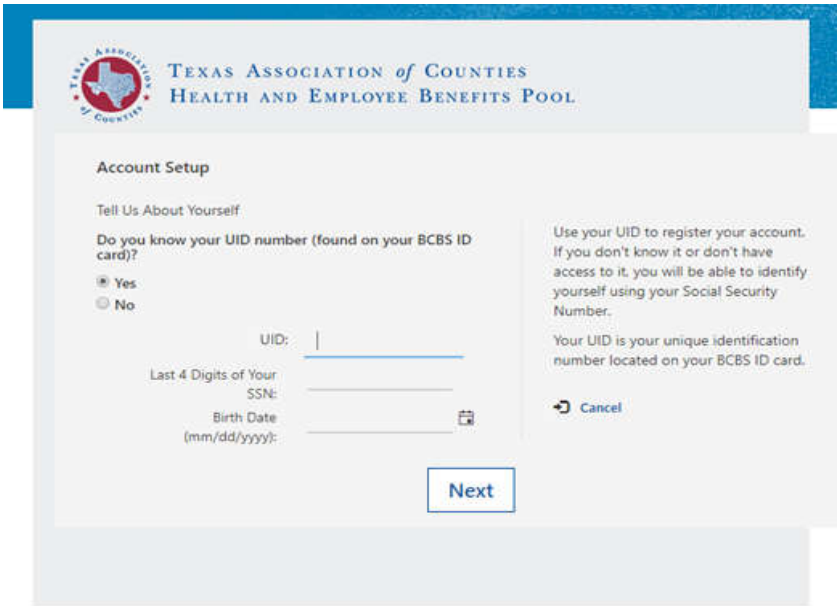
First-time users will need to set up an account using a unique password before logging onto the ESS portal.

From the mybenefits.county.org page, *first-time users* should click on the ***Create an account*** link displayed at the bottom of the window.

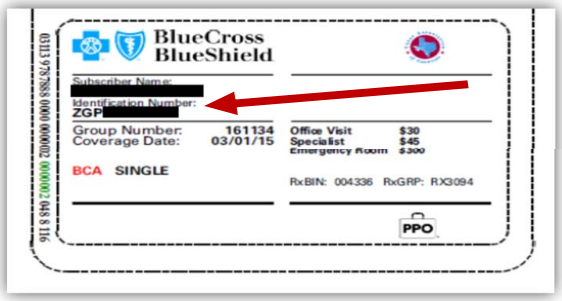
First-time users will need to follow the steps on each screen, then acknowledge and accept an online authorization.

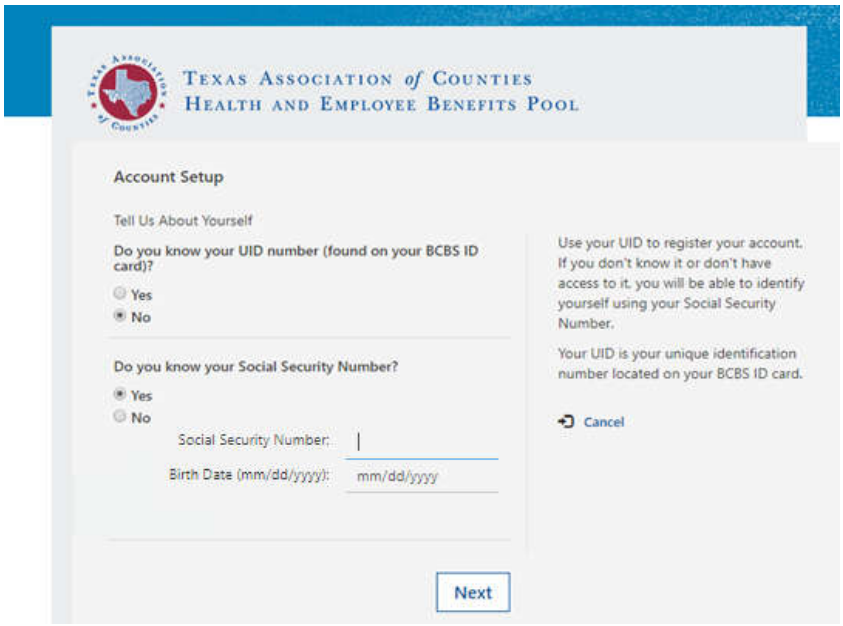


Step 1. Create an account

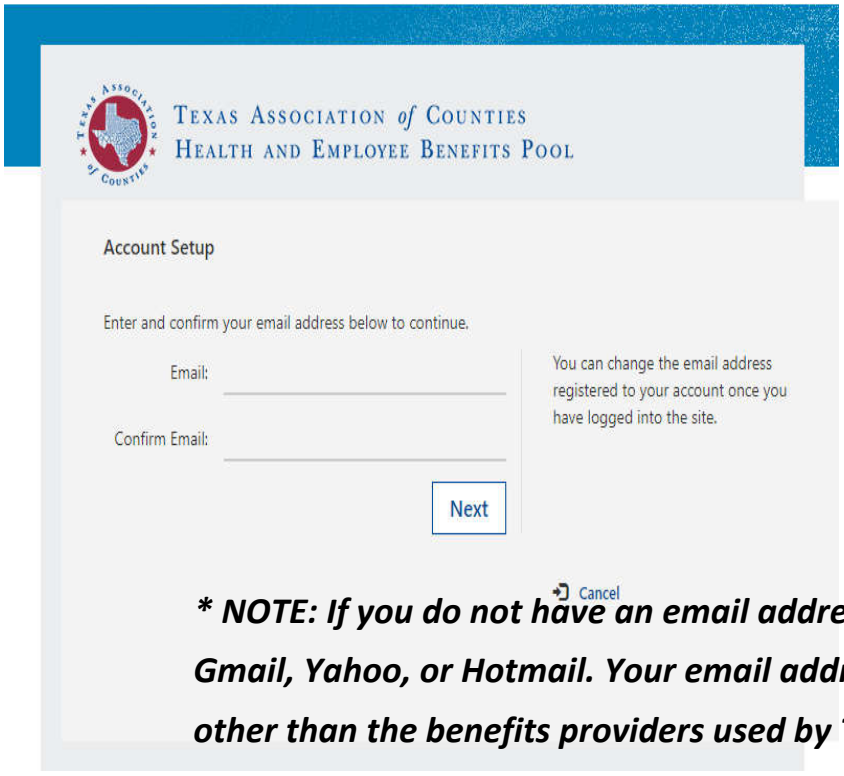


Step 2. Locate your record in the OASys system using your UID





If you don't know your UID, locate your record in the OASys system using your SSN and date of birth



Step 3. Establish Username*

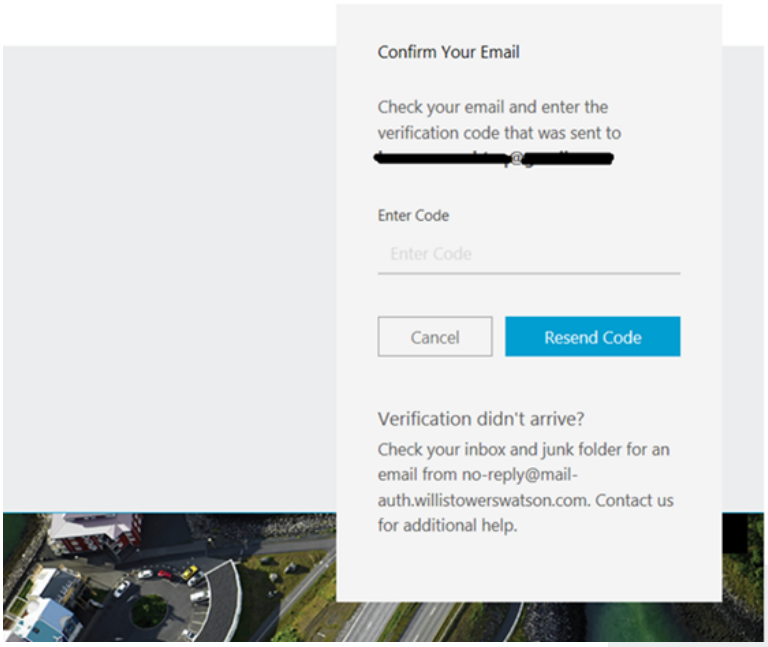
**** NOTE: If you do not have an email address, you can set one up for free at Gmail, Yahoo, or Hotmail. Your email address will not be shared with any entity other than the benefits providers used by TAC HEBP (Blue Cross, Navitus, etc.)***

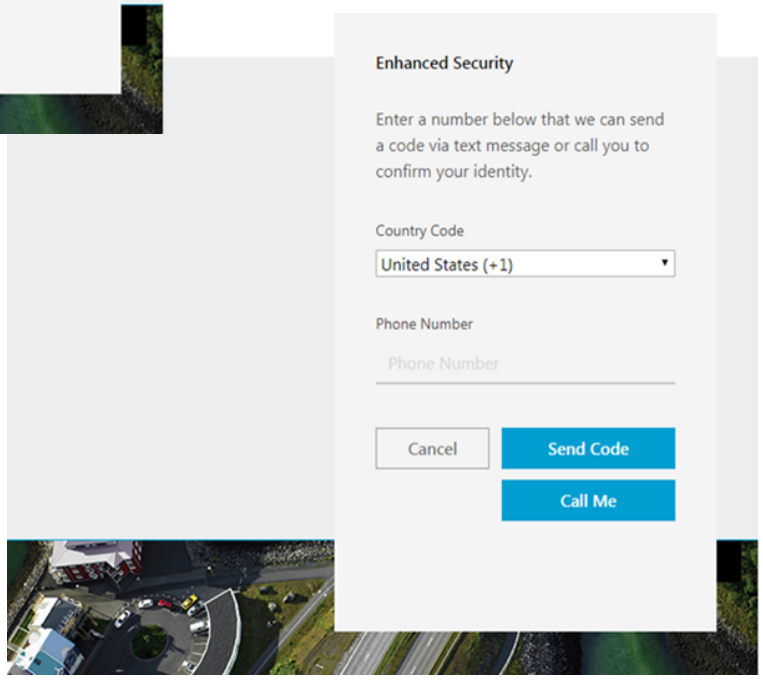
Step 4. Proceed through Multi-Factor Authentication steps on the next page, then set your Password. You're ready to begin using ESS!

MULTI-FACTOR AUTHENTICATION

Because this site contains access to your Protected Health Information (PHI), enhanced security steps are required. "Multi-factor authentication" means the system will require more than one way to verify your identity.

Multi-factor authentication will be required each time you log onto the portal.





NOTE: If you do not have an email address, you can set one up for free at Gmail, Yahoo, or Hotmail. Your email address will not be shared with any entity other than the benefits providers used by TAC HEBP (Blue Cross, Navitus, etc.)

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II.
Benefit Highlights

TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

BENEFIT HIGHLIGHTS
GALVESTON COUNTY CUSTOM HDHP
(Embedded Deductible)

BLUECHOICE NETWORK

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	PPO In-Network	Non-PPO Out-of-Network
Plan Year Deductibles *Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)*		
Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual. *NOTE: The individual Deductible amount must be equal to or greater than the minimum family Deductible amount. This qualification is established by the U.S. Treasury for a plan to be considered a qualified HSA plan.*	*$3,000 Individual / $6,000 Family*	*$6,000 Individual / $12,000 Family*
3-Month Deductible Carryover Applies	*No*	*No*
Plan Year Total Out-of-Pocket Maximum		
Individual & Family Deductible, Coinsurance Amounts and Copayments (if any) apply to Out-of-Pocket Maximum. Your benefit booklet will provide more details.	*$6,450 Individual / $12,900 Family* *Network Deductible & Out-of-Pocket Maximum **will only** apply toward Network Deductible & Out-of-Pocket Maximum*	*Unlimited* *Out-of-Network Deductible & Out-of-Pocket Maximum **do not** apply toward Network Deductible & Out-of-Pocket Maximum*
MDLIVE (Telemedicine & Behavioral Health)	*80% of Allowable Amount after Plan Year Deductible*	*Not Applicable*
Livongo *(Participants must enroll in this program to receive a glucometer, unlimited diabetic test strips and lancets)*	*100% of Allowable Amount (Deductible Waived)*	*Not Applicable*
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	

Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
Inpatient Hospital Expenses (including Maternity Care)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Penalty for failure to preauthorize services	*None*	*$500*

Medical/Surgical Expenses	PPO In-Network	Non-PPO Out-of-Network
Medical / Surgical Expenses		
Physician office visit/consultation, including lab & x-ray	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Physician surgical services in any setting and Maternity Care	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Lab & x-ray in other outpatient facilities and Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Home Infusion Therapy (Services must be preauthorized)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
All other outpatient services and supplies	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
In Vitro Fertilization Services	*Not Covered*	

Extended Care Expenses

Extended Care Expenses

All services must be preauthorized

Skilled Nursing Facility Home Health Care	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Hospice Care	*Unlimited*	

Special Provisions Expenses

☆Treatment of Chemical Dependency

All services must be preauthorized

Inpatient Services must be provided in a Chemical Dependency Treatment Center	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
All other outpatient treatment	*Covered as any other physical illness*	

☆Serious Mental Illness / Mental Health Care

All services must be preauthorized

Inpatient Services Hospital services (facility)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Physician services	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Outpatient Services Services performed during Physician office visit/consultation, including lab & x-ray	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Other outpatient services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*

Emergency Room/ Outpatient Hospital Emergency Room

Accidental Injury & Medical Emergency Care Facility charges	*80% of Allowable Amount after Plan Year Deductible*	
Physician charges	*80% of Allowable Amount after Plan Year Deductible*	
Non-Emergency Situations Facility charges	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Physician charges	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*

Urgent Care

Urgent Care center visit, including all lab & x-ray services, Certain Diagnostic Procedures, and all other services and supplies	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*

* All benefit payments made for both In-Network and Out-of-Network services will apply toward any maximum amounts indicated.

☆Mental Health Parity and Addiction Equity Act of 2008: The Mental Health Parity and Addiction Equity (MHPAE) Act is a federal law that applies to employers who employed an average of more than 50 employees on business days during the preceding Plan Year. The law generally requires that group health insurers apply the same treatment and financial limits to mental health and substance use disorder benefits as apply to the predominant medical- surgical benefits of the plan. If this law applies to your coverage, you will receive a Benefit Highlights amendment form that shows your mental health and substance use disorder (chemical dependency) benefits.

Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations and any other preventive health services as determined by USPSTF	*100% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Routine Colonoscopy	*100% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Special Provisions Expenses, cont.	**PPO** *In-Network*	**Non-PPO** *Out-of-network*
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Physical Medicine Services		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Airrosti Rehab Centers	*80% of Allowable Amount after Plan Year Deductible*	*Not Applicable*

* All benefit payments made for both In-Network and Out-of-Network services will apply toward any maximum amounts indicated.

EMPLOYEE INFORMATION

This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.

MDLIVE (Telemedicine & Behavioral Health) are part of your benefit plan design. Access to an independently contracted board certified doctor is available 24 hours a day, seven days a week to speak to immediately or schedule an appointment based on your availability. Please refer to your benefit booklet for other details.

The following applies to dependent coverage:

- Dependent children are covered to age 26;
- Dependent children are covered for maternity benefits;
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are also based on the BCBSTX-determined Allowable Amount. Covered individuals will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the Contract Date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible Expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool. n addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all extraterritorial requirements of those states

Coverage is contingent upon the following:

- The employer must maintain enrollment of at least 75% of eligible employees and pay at least 50% of the employee only cost.
- The replacement of coverage stipulation in the contract.

Deductible (Embedded): The benefits of the Plan will be available after satisfaction of the applicable Deductible. The Deductible will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U). The Deductibles are explained as follows:

1. The individual Deductible amount as shown on this Benefits Highlights under "Plan Year Deductible," must be satisfied by each Participant under your coverage each Plan Year. This Deductible, unless otherwise indicated, will apply to all combined Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses you incur during a Plan Year.
2. If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount shown on this Benefits Highlights. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Plan Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.

Out-of-Pocket Maximum: Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

1. The Out-of-Pocket Maximum will not include:

- Services, supplies, or charges limited or excluded by the Plan;
- Expenses not covered because of a benefit maximum has been reached;
- Any Eligible Expense paid by the Primary Plan when BCBXTX is the Secondary Plan for purposes of coordination of benefits;
- Penalties for failing to obtain preauthorization;

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

± Please be reminded that Health Savings Accounts (HSA's) have tax and legal ramifications. Blue Cross and Blue Shield of Texas does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

BENEFIT HIGHLIGHTS GALVESTON COUNTY CUSTOM BASE PLAN

(Non-Grandfathered ACA Plan)

BLUECHOICE NETWORK

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Plan Year Deductibles		
Deductible *Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)*	*$2,000 Individual / $4,000 Family*	*$4,000 Individual / $8,000 Family*
3-Month Deductible Carryover Applies	*Yes*	*No*
Plan Year Total Out-of-Pocket Maximum		
Individual & Family Deductibles and Copayments are applied to the Out-of-Pocket Maximum. Copayment Amounts will not be required after Out-of-Pocket Maximum has been satisfied. Your benefit booklet will provide more details.	*$7,000 Individual / $17,100 Family* *Network Deductible & Out-of-Pocket Maximum **will only** apply toward Network Deductible & Out-of-Pocket Maximum*	*Unlimited* *Out-of-Network Deductible & Out-of-Pocket Maximum **do not** apply toward Network Deductible & Out-of-Pocket Maximum*
Copayment Amounts Required		
Physician office visit/consultation *Refer to Medical/Surgical Expenses section for more information*	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Urgent Care	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
MDLIVE (Telemedicine)	*$10 Copayment Amount*	*Not Applicable*
MDLIVE (Behavioral Health)	*$35 Copayment Amount*	*Not Applicable*
Livongo *(Participants must enroll in this program to receive a glucometer, unlimited diabetic test strips and lancets)*	*100% of Allowable Amount (Deductible Waived)*	*Not Applicable*
Outpatient Hospital Emergency Room/Treatment Room *Refer to Emergency Room/Treatment Room section for more information*	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Per Hospital Admission	*$100 Copayment Amount*	*$500 Copayment Amount*
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	

Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units (including Maternity Care)	*$100 Hospital Admission Copayment Amount and 80% of Allowable Amount after Plan Year Deductible*	*$500 Hospital Admission Copayment Amount and 50% of Allowable Amount after Plan Year Deductible*
Penalty for failure to preauthorize services	*None*	*$500*

BlueCross BlueShield of Texas

Medical/Surgical Expenses	In-Network Benefits	Out-of-Network Benefits
Medical / Surgical Expenses		
Services performed during the Physician's office visit/consultation, including lab & x-ray *(does not include Certain Diagnostic Procedures and surgical services)*	*80% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Allergy Injections	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Physician surgical services performed in any setting (including Maternity Care)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Organ Transplants	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
TMJ Treatments	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
All other outpatient services and supplies	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
In Vitro Fertilization Services	*Not Covered*	
Extended Care Expenses		
Extended Care Expenses		
All services must be preauthorized		
Skilled Nursing Facility Home Health Care	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Hospice Care	*Unlimited*	
Special Provisions Expenses		
Serious Mental Illness		
All services must be preauthorized		
Inpatient Services		
-Hospital services (facility)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
-Physician services	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Outpatient Services		
-Services performed during Physician office visit/consultation (does not include psychological testing)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
-All outpatient services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Mental Health Care/Chemical Dependency		
All services must be preauthorized		
Inpatient Services		
-Hospital services (facility)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
-Physician services	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Outpatient Services		
-Services performed during Physician office visit/consultation *(does not include psychological testing)*	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
-Emergency Room/Treatment Room	*80% of Allowable Amount after Plan Year Deductible* *($100 Per Hospital Admission Copayment if admitted, Inpatient Hospital Expenses will apply)*	*50% of Allowable Amount after Plan Year Deductible* *($500 Per Hospital Admission Copayment if admitted, Inpatient Hospital Expenses will apply)*
-Other Outpatient Services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Chemical Dependency Maximum *(Inpatient treatment must be provided in a Chemical Dependency Treatment Center)*	*Unlimited*	
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care		
-Facility charges (outpatient Hospital emergency treatment room charges)	*80% of Allowable Amount after Plan Year Deductible* *($100 Per Hospital Admission Copayment if admitted, Inpatient Hospital Expenses will apply)*	
-Physician charges	*80% of Allowable Amount after Plan Year Deductible*	
Non-Emergency Care		
-Facility charges (outpatient Hospital emergency treatment room charges)	*80% of Allowable Amount after Plan Year Deductible* *($100 Per Hospital Admission Copayment if admitted, Inpatient Hospital Expenses will apply)*	*50% of Allowable Amount after Plan Year Deductible* *($500 Per Hospital Admission Copayment if admitted, Inpatient Hospital Expenses will apply)*
-Physician charges	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
-Non-Emergency Ground (Air ambulance services are not available for non-emergencies)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Ground and Air Ambulance Services		
	80% of Allowable Amount after Plan Year Deductible	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, vision exams, hearing exams, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Routine Colonoscopy	*100% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Physical Medicine Services		
Chiropractic Care-Office Services	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Airrosti Rehab Centers	*80% of Allowable Amount after Plan Year Deductible*	*Not Applicable*
	All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

EMPLOYEE INFORMATION

This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.

MDLIVE (Telemedicine & Behavioral Health) are part of your benefit plan design. Access to an independently contracted board certified doctor is available 24 hours a day, seven days a week to speak to immediately or schedule an appointment based on your availability. Please refer to your benefit booklet for other details.

The following benefits apply to dependent coverage:

- Dependent children are covered to age 26.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount, except in the event of Emergency Care received in an outpatient hospital emergency treatment room within 48 hours of the incident. For all other services received by an Out-of-Network Provider, the covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

BENEFIT HIGHLIGHTS
GALVESTON COUNTY
CUSTOM BUY-UP PLAN
(Non-Grandfathered ACA)

BLUECHOICE NETWORK

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Plan Year Deductibles		
Deductible *Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)*	*$1,250 Individual / $3,750 Family*	*$2,000 Individual / $6,000 Family*
3-Month Deductible Carryover Applies	*Yes*	*No*
Plan Year Total Out-of-Pocket Maximum		
Individual & Family Deductibles and Copayments are applied to the Out-of-Pocket Maximum. Copayment Amounts will not be required after Out-of-Pocket Maximum has been satisfied. Your benefit booklet will provide more details.	*$4,500 Individual / $13,500 Family* *Network Deductible & Out-of-Pocket Maximum **will only** apply toward Network Deductible & Out-of-Pocket Maximum*	*Unlimited* *Out-of-Network Deductible & Out-of Pocket Maximum **do not** apply toward Network Deductible & Out-of-Pocket Maximum*
Copayment Amounts Required		
Physician office visit/consultation *Refer to Medical/Surgical Expenses section for more information*	*$25 Copayment Amount*	*50% of Allowable Amount after Plan Year Deductible*
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	*$25 Copayment Amount*	*50% of Allowable Amount after Plan Year Deductible*
Urgent Care	*$25 Copayment Amount*	*50% of Allowable Amount after Plan Year Deductible*
MDLIVE (Telemedicine)	*$10 Copayment Amount*	*Not Applicable*
MDLIVE (Behavioral Health)	*$35 Copayment Amount*	*Not Applicable*
Livongo *(Participants must enroll in this program to receive a glucometer, unlimited diabetic test strips and lancets)*	*100% of Allowable Amount (Deductible Waived)*	*Not Applicable*
Outpatient Hospital Emergency Room/Treatment Room *Refer to Emergency Room/Treatment Room section for more information*	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Per Hospital Admission	*$100 Copayment Amount*	*$500 Copayment Amount*
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized *All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units (including Maternity Care)*	*$100 Hospital Admission Copayment Amount and 80% of Allowable Amount after Plan Year Deductible*	*$500 Hospital Admission Copayment Amount and 50% of Allowable Amount after Plan Year Deductible*
Penalty for failure to preauthorize services	*None*	*$500*

BlueCross BlueShield of Texas

Medical/Surgical Expenses	In-Network Benefits	Out-of-Network Benefits
Medical / Surgical Expenses		
Services performed during the Physician's office visit/consultation, including lab & x-ray *(does not include Certain Diagnostic Procedures and surgical services)*	*80% of Allowable Amount after $25 Copayment Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Allergy Injections	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Physician surgical services performed in any setting (including Maternity Care)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Organ Transplants	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
TMJ Treatments	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
All other outpatient services and supplies	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
In Vitro Fertilization Services	*Not Covered*	
Extended Care Expenses		
Extended Care Expenses *All services must be preauthorized*		
Skilled Nursing Facility Home Health Care	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Hospice Care	*Unlimited*	
Special Provisions Expenses		
Serious Mental Illness *All services must be preauthorized*		
Inpatient Services		
-Hospital services (facility)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
-Physician services	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Outpatient Services		
-Services performed during Physician office visit/consultation (does not include psychological testing)	*80% of Allowable Amount after $25 Copayment*	*50% of Allowable Amount after Plan Year Deductible*
-All outpatient services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Mental Health Care/Chemical Dependency		
All services must be preauthorized		
Inpatient Services		
-Hospital services (facility)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
-Physician services	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Outpatient Services		
-Services performed during Physician office visit/consultation *(does not include psychological testing)*	*80% of Allowable Amount after $25 Copayment Amount*	*50% of Allowable Amount after Plan Year Deductible*
-Emergency Room/Treatment Room	*80% of Allowable Amount after Plan Year Deductible* *(If admitted, $100 per Hospital Admission Fee and Inpatient Hospital Expenses will apply)*	*50% of Allowable Amount after Plan Year Deductible* *(If admitted, $500 per Hospital Admission Fee and Inpatient Hospital Expenses will apply)*
-Other Outpatient Services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Chemical Dependency Maximum *(Inpatient treatment must be provided in a Chemical Dependency Treatment Center)*	*Unlimited*	
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care		
-Facility charges (outpatient Hospital emergency treatment room charges)	*80% of Allowable Amount after Plan Year Deductible (If admitted, $100 per Hospital Admission Fee and Inpatient Hospital Expenses will apply)*	
-Physician charges	*80% of Allowable Amount after Plan Year Deductible*	
Non-Emergency Care		
-Facility charges (outpatient Hospital emergency treatment room charges)	*80% of Allowable Amount after Plan Year Deductible* *(If admitted, $100 per Hospital Admission Fee and Inpatient Hospital Expenses will apply)*	*50% of Allowable Amount after Plan Year Deductible* *(If admitted, $500 per Hospital Admission Fee and Inpatient Hospital Expenses will apply)*
-Physician charges	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
-Non-Emergency Ground (Air ambulance services are not available for non-emergencies)	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Ground and Air Ambulance Services	*80% of Allowable Amount after Plan Year Deductible*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, vision exams, hearing exams, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Routine Colonoscopy	*100% of Allowable Amount (Deductible Waived)*	*50% of Allowable Amount after Plan Year Deductible*
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Physical Medicine Services		
Chiropractic Care-Office Services	*80% of Allowable Amount after Plan Year Deductible*	*50% of Allowable Amount after Plan Year Deductible*
Airrosti Rehab Centers	*$25 Copayment Amount*	*Not Applicable*
	All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

EMPLOYEE INFORMATION

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Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount, except in the event of Emergency Care received in an outpatient hospital emergency treatment room within 48 hours of the incident. For all other services received by an Out-of-Network Provider, the covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

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PRESCRIPTION DRUG PLAN
GALVESTON COUNTY CUSTOM RX PLAN - HDHP

Prescription Drug Program

Up to a 90-day Supply at Participating Navitus Health Solutions Network Retail Pharmacy or Mail Service Pharmacy

Plan Year Deductible	*$0 Individual / $0 Family*		
Per Days Supply	*0-30 Days*	*31-60 Days*	*61-90 Days*
Tier 4 Drug[2]	*10% up to $100*	*NA*	*NA*
Tier 3 Drug	*$45*	*$90*	*$112*
Tier 2 Drug	*$35*	*$70*	*$88*
Tier 1 Drug	*Lesser of $10 Copayment Amount OR Actual Cost*	*$20*	*$25*
*CareHere Pharmacy (Generics Only)[3]	*$0*	*$0*	*$0*

ATTENTION: Please note the following guidelines regarding your Prescription benefits:

1) Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name Copayment.
2) Specialty and biotech medications are available only through mail order unless purchased and administered through the doctor's office.
3) CareHere Pharmacy is currently not in the Navitus network. However, if contract is awarded, Navitus is willing to contract with CareHere Pharmacy, which would take 30-60 days.
4) Rx copays will apply after the medical deductible has been satisfied.

Note: Prescription Drug Benefits are provided by Navitus Health Solutions through a master contract with the Texas Association of Counties Health and Employee Benefits Pool. Prescription Drugs are not administered by Blue Cross and Blue Shield of Texas

PRESCRIPTION DRUG PLAN
GALVESTON COUNTY CUSTOM BASE RX PLAN

Prescription Drug Program

Up to a 30-day Supply at Participating Navitus Health Solutions Network Retail Pharmacy or Mail Service Pharmacy

Plan Year Deductible	*$0 Individual / $0 Family*		
Per Days Supply	*0-30 Days*	*31-60 Days*	*61-90 Days*
Tier 4 Drug[2]	*10% up to $140*	*NA*	*NA*
Tier 3 Drug	*$60*	*$120*	*$150*
Tier 2 Drug	*$45*	*$90*	*$110*
Tier 1 Drug	*Lesser of $14 Copayment Amount OR Actual Cost*	*$28*	*$35*
CareHere Pharmacy (Generics Only)[3]	*$0*	*$0*	*$0*

ATTENTION: Please note the following guidelines regarding your Prescription benefits:

1) Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name Copayment.
2) Specialty and biotech medications are available only through mail order unless purchased and administered through the doctor's office.
3) CareHere Pharmacy is currently not in the Navitus network. However, if contract is awarded, Navitus is willing to contract with CareHere Pharmacy, which would take 30-60 days.

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PRESCRIPTION DRUG PLAN
GALVESTON COUNTY CUSTOM BUY-UP RX PLAN

Prescription Drug Program

Up to a 30-day Supply at Participating Navitus Health Solutions Network Retail Pharmacy or Mail Service Pharmacy

Plan Year Deductible	*$0 Individual / $0 Family*		
Per Days Supply	*0-30 Days*	*31-60 Days*	*61-90 Days*
Tier 4 Drug[2]	*10% up to $152*	*NA*	*NA*
Tier 3 Drug	*$68*	*$137*	*$170*
Tier 2 Drug	*$53*	*$106*	*$134*
Tier 1 Drug	*Lesser of $16 Copayment Amount OR Actual Cost*	*$30*	*$38*
CareHere Pharmacy (Generics Only)[3]	*$0*	*$0*	*$0*

ATTENTION: Please note the following guidelines regarding your Prescription benefits:

1) Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name Copayment.
2) Specialty and biotech medications are available only through mail order unless purchased and administered through the doctor's office.
3) CareHere Pharmacy is currently not in the Navitus network. However, if contract is awarded, Navitus is willing to contract with CareHere Pharmacy, which would take 30-60 days.

Note: Prescription Drug Benefits are provided by Navitus Health Solutions through a master contract with the Texas Association of Counties Health and Employee Benefits Pool. Prescription Drugs are not administered by Blue Cross and Blue Shield of Texas

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III.
BCBSTX Medical

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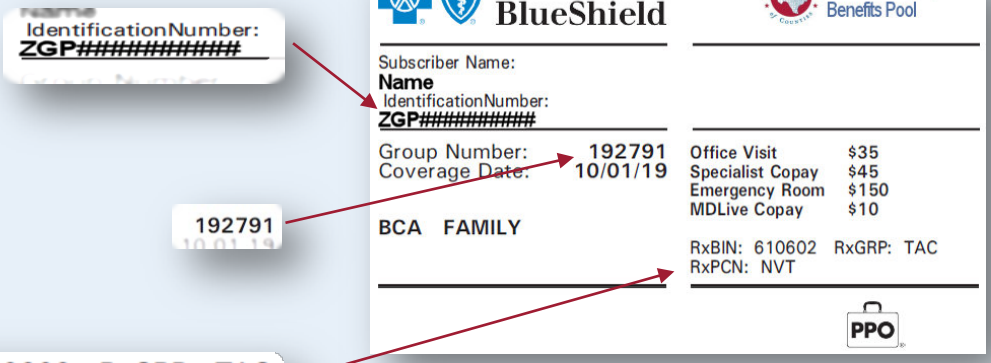
TEXAS ASSOCIATION of COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL

YOUR TAC HEBP / BLUE CROSS BLUE SHIELD IDENTIFICATION CARD

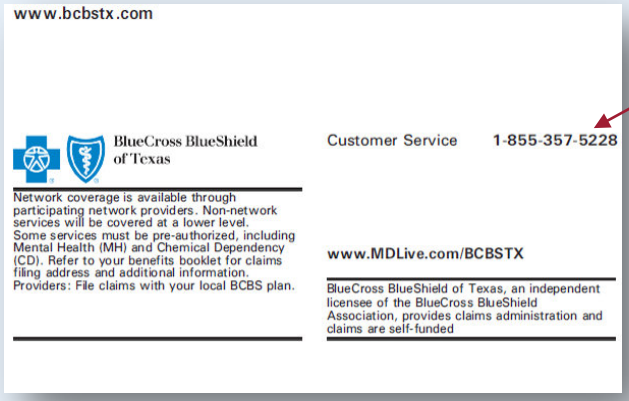
FRONT

The Identification Number (UID) and Group Number identify you and allow providers to verify your benefits



This information is used by your pharmacy to fill prescriptions

BACK



Call the **Customer Service Number** on the back of your ID card for assistance with these benefits:

- Medical
- Prescriptions (Navitus)
- MDLive (Telemedicine)
- 24/7 Nurseline
- Dental (if provided through TAC)
- Vision (if provided through TAC)

Take Advantage of Preventive Services

Your family's race to better health begins with a single step: Taking advantage of preventive health care services

Preventive check-ups and screenings can help find illnesses and medical problems early and improve the health of you and everyone in your family.

Your health plan covers screenings and services with no out-of-pocket costs like copays or coinsurance as long as you visit a doctor in your plan's provider network. This is true even if you haven't met your deductible.

Some examples of preventive care services covered by your plan include general wellness exams each year, recommended vaccines, and screenings for things like diabetes, cancer or depression. Preventive services are provided for women, men and children of all ages.

For more details on what preventive services are covered at no cost to you, refer to the back of this flier for a listing of services, or see your benefits materials.

Learn more on immunization recommendations and schedules by visiting the Centers for Disease Control and Prevention website at **cdc.gov/vaccines**.

745188.0417

These preventive services are covered by your plan at no cost to you[1]

FOR ADULTS

Annual preventive medical history and physical exam

OVER 18

SCREENINGS FOR

- ☐ Abdominal aortic aneurysm
- ☐ Alcohol abuse and tobacco use
- ☐ Colorectal and lung cancer
- ☐ Depression
- ☐ Falls prevention and vitamin D use for stronger bones
- ☐ High blood pressure, high cholesterol, obesity, diabetes and depression
- ☐ Sexually transmitted infections, HIV, HPV and hepatitis

COUNSELING FOR

- ☐ Alcohol misuse
- ☐ Domestic violence
- ☐ Healthy diet and physical activity counseling for adults who are overweight or obese and have additional cardiovascular risk disease factors
- ☐ Obesity
- ☐ Sexually transmitted infections
- ☐ Skin cancer prevention
- ☐ Tobacco use, including certain medicine to stop
- ☐ Use of aspirin to prevent heart attacks

FOR CHILDREN

Annual preventive medical history and physical exam

SCREENINGS FOR

- ☐ Autism
- ☐ Cervical dysplasia
- ☐ Depression
- ☐ Developmental delays
- ☐ Dyslipidemia (for children at higher risk)
- ☐ Hearing loss, hypothyroidism, sickle cell disease and phenylketonuria (PKU) in newborns
- ☐ Hematocrit or hemoglobin
- ☐ Lead poisoning
- ☐ Obesity
- ☐ Sexually transmitted infections and HIV
- ☐ Tuberculosis
- ☐ Visual acuity

ASSESSMENTS AND COUNSELING

- ☐ Alcohol and drug use assessment for adolescents
- ☐ Obesity counseling
- ☐ Oral health risk assessment, dental caries prevention fluoride varnish and oral fluoride supplements
- ☐ Skin cancer prevention counseling

JUST FOR WOMEN

- ☐ Aspirin for preeclampsia prevention
- ☐ Breast cancer screening, genetic testing and counseling
- ☐ Breastfeeding support, supplies and counseling
- ☐ Certain contraceptives and medical devices, morning after pill, and sterilization to prevent pregnancy
- ☐ Cervical cancer screening
- ☐ Chlamydia, gonorrhea, syphilis, HIV and hepatitis B screenings
- ☐ Counseling for alcohol and tobacco use during pregnancy
- ☐ Folic acid supplementation during pregnancy
- ☐ Human papillomavirus (HPV) DNA test
- ☐ Osteoporosis screening
- ☐ Screenings during pregnancy, including screenings for anemia, gestational diabetes, bacteriuria, Rh(D) compatibility

CERTAIN VACCINES

Learn more on immunization recommendations and schedules by visiting: **cdc.gov/vaccines**

- ☐ Diphtheria, Pertussis, Tetanus
- ☐ Haemophilus Influenzae Type B (Hib)
- ☐ Hepatitis A and B
- ☐ Human Papillomavirus (HPV)
- ☐ Inactivated Poliovirus (Polio)
- ☐ Influenza (Flu)
- ☐ Measles, Mumps, Rubella (MMR)
- ☐ Meningitis
- ☐ Pneumococcal
- ☐ Rotavirus
- ☐ Varicella (Chicken Pox)
- ☐ Zoster (Herpes, Shingles)

bcbstx.com

[1] Non grandfathered health plans are required by the Affordable Care Act to provide coverage for preventive care services without cost sharing only when the member uses a network provider. You may have to pay all or part of the cost of preventive care if your health plan is grandfathered. To find out if your plan is grandfathered or non grandfathered, call the Customer Service number listed on your member ID card.

BlueCross BlueShield of Texas

Texas Association of Counties Health and Employee Benefits Pool

Confused About Where to Go for Care?

SmartER Care℠ options may save you money.

If you aren't having an emergency, deciding where to go for medical care may save you time and money.

You have choices for where you get non-emergency care — what we call SmartER Care. Use the chart below to help you figure out when to use each type of care.

When you use in-network providers for your family's health care, you usually pay less for care. Search for in-network providers in your area at **https://mybenefits.county.org**. Select **Get Connected** and click on the **Blue Cross and Blue Shield** link. Use the information on your member ID card to complete the process. You may also call the Customer Service number on the back of your member ID card.

Virtual Visits

- Available 24 hours a day, seven days a week
- Access to care for non-emergency medical issues whether you're at home or traveling
- Based on your location, have a doctor or behavioral health professional visit by phone at **888-680-8646**, online at **MDLIVE.com/bcbstx** or with the MDLIVE® mobile app[1]
- Average wait time is less than 20 minutes
- Powered by MDLIVE

$

Doctor's Office

- Office hours vary
- Generally the best place to go for non-emergency care
- Doctor-to-patient relationship established and therefore able to treat, based on knowledge of medical history
- Average wait time is 18 minutes[2]

$

Retail Health Clinic

- Based upon retail store hours
- Usually lower out-of-pocket cost to you than urgent care
- Often located in stores and pharmacies to provide convenient, low-cost treatment for minor medical problems

$

Urgent Care Center

- Generally includes evenings, weekends and holidays
- Often used when your doctor's office is closed, and you don't consider it an emergency
- Average wait time is 16-24 minutes[3]
- Many have online and/or telephone check-in

$ $

Hospital ER

- Open 24 hours, seven days a week
- Average wait time is 4 hours, 7 minutes[4]
- If you receive care from an out-of-network provider, you may have to pay more. Providers outside the network may "balance bill" you, which means they may charge you more than your health plan's fee schedule.
- Multiple bills for services such as doctors and facility

$ $ $

Freestanding ER

- Open 24 hours, seven days a week
- Could be transferred to a hospital-based ER depending on medical situation
- Services do not include trauma care
- Often freestanding ERs are out-of-network. If you receive care from an out-of-network provider, you may have to pay more. Providers outside the network may "balance bill" you, which means they may charge you more than your health plan's fee schedule.
- All freestanding ERs charge a facility fee that urgent care centers do not. You may receive other bills for each doctor you see.[5]

$ $ $ $

If you need emergency care, call 911 or seek help from any doctor or hospital immediately.

[1] Internet/Wi-Fi connection is needed for computer access. Data charges may apply. Check your cellular data or internet service provider's plan for details. Non-emergency medical service in Idaho, Montana and New Mexico is limited to interactive audio/video (video only), along with the ability to prescribe. Non-emergency medical service in Arkansas is limited to interactive audio/video (video only) for initial consultation, along with the ability to prescribe. Behavioral Health service is limited to interactive audio/video (video only), along with the ability to prescribe in all states. Service availability depends on location at the time of consultation.

[2] Vitals Annual Wait Time Report, 2017.

[3] Wait Time Trends in Urgent Care and Their Impact on Patient Satisfaction, 2017.

[4] Emergency Department Pulse Report 2010 Patient Perspectives on American Health Care. Press Ganey Associates.

[5] The Texas Association of Health Plans.

Note: The relative costs described here are for independently contracted network providers. Your costs for out-of-network providers may be significantly higher. Wait times described are just estimates.

Virtual visits, Powered by MDLIVE may not be available on all plans. Virtual visits are subject to the terms and conditions of your benefit plan, including benefits, limitations, and exclusions. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE is not an insurance product or a prescription fulfillment warehouse. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services.

The information provided in this guide is not intended as medical advice, nor meant to be a substitute for the individual medical judgment of a doctor or other health care professional. Please check with your doctor for individualized advice on the information provided. Coverage may vary depending on your specific benefit plan and use of network providers. For questions, please call the number on the back of your member ID card.

Deciding Where to Go? Virtual Visit, Doctor's Office, Retail Clinic, Urgent Care or ER.

	Virtual Visits powered by MDLIVE	Doctor's Office	Retail Health Clinic	Urgent Care Center	Hospital ER	Freestanding ER
						
Who usually provides care	**Primary Care Pediatrics, Family and Emergency Medicine Doctors**	**Primary Care Doctor**	**Physician Assistant or Nurse Practitioner**	**Internal Medicine, Family Practice and Pediatric**	**ER Doctors, Internal Medicine, Specialists**	**ER Doctors**
Sprains, strains		■	■	■	• Any life-threatening or disabling conditions • Sudden or unexplained loss of consciousness • Major injuries • Chest pain; numbness in the face, arm or leg; difficulty speaking • Severe shortness of breath • High fever with stiff neck, mental confusion or difficulty breathing • Coughing up or vomiting blood • Cut or wound that won't stop bleeding • Possible broken bones	• Most major injuries except for trauma[1] • May also provide imaging and lab services but do not offer trauma or cardiac services requiring catheterization[1] • Do not always accept ambulances
Animal bites		■	■	■		
X-rays				■		
Stitches				■		
Mild asthma	■	■	■	■		
Minor headaches	■	■	■	■		
Back pain		■	■	■		
Nausea, vomiting, diarrhea	■	■	■	■		
Minor allergic reactions	■	■	■	■		
Coughs, sore throat	■	■	■	■		
Bumps, cuts, scrapes	■	■	■	■		
Rashes, minor burns	■	■	■	■		
Minor fevers, colds	■	■	■	■		
Ear or sinus pain	■	■	■	■		
Burning with urination	■	■	■	■		
Eye swelling, irritation, redness or pain	■	■	■	■		
Vaccinations		■	■	■		

24/7 Nurseline[2]

The 24/7 Nurseline can help you identify some options when you or a family member have a health problem or concern. Nurses are available at **800-581-0393**, 24 hours a day, seven days a week, to answer your health questions.

Urgent Care Center or Freestanding ER

Knowing the Difference Can Save You Money

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs often look a lot like urgent care centers, but costs may be higher. A visit to a freestanding ER often results in medical bills that may be 10 times the rate charged by urgent care centers for the same services.[3] Here are some ways to know if you are at a freestanding ER.

Freestanding ERs:

- Look like urgent care centers, but have the word "Emergency" in their name or on the building.
- Are open 24 hours a day, seven days a week.
- Are not attached to and may not be affiliated with a hospital.
- Are subject to the same ER member share which may include a copay, coinsurance and applicable deductible.

Find urgent care centers[4] near you by texting[5] **URGENTTX** to **33633**.

[1] "Freestanding ED 101: What you need to know" July 2016, The Advisory Board Company.

[2] 24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

[3] Freestanding ERs: The Need for Greater Transparency and More Consumer Protections. (2016). The Texas Association of Health Plans.

[4] The closest urgent care center may not be in your network. Be sure to check Provider Finder® to make sure the center you go to is in-network.

[5] Message and data rates may apply. Read terms, conditions and privacy policy at bcbstx.com/mobile/text-messaging.

747802.0618

BlueCross BlueShield of Texas

SAVE MONEY WITH **IN-NETWORK PROVIDERS** and Avoid **"BALANCE BILLING"**

Get the most from your health plan benefits by using in-network providers when possible. Use Provider Finder® from Blue Cross and Blue Shield of Texas (BCBSTX) when you need to find a doctor, hospital or other facility. This may help lower your out-of-pocket costs.

Knowing how your plan works can help you save.
Doctors, hospitals, clinics and urgent care facilities (these are all called "providers") who contract independently with the PPO network have agreed to accept our negotiated rates as payment in full. When you receive care from a network provider, you will usually pay less out of pocket than at an out-of-network provider.

If you receive care from a provider that is outside the PPO network, you may have to pay more for your care or even the full cost if it is not a covered service.
Providers outside the network may "balance bill" you, which means they may charge you more than what your health plan pays and up to the provider's billed charge. Examples of out-of-network providers you may encounter include emergency room and hospital-based physicians. It is possible that a hospital is in the network, but a doctor or other provider treating you there may be out of network. When possible, ask if all providers that will be providing services are in the network for your plan.

Before you go for medical care, make sure the doctor or hospital is part of the PPO network.
There are several ways to find a PPO network provider:

- Register or log in to Blue Access for Members℠, our secure member website at **https://mybenefits.county.org**. Click on **Benefits**, then select **Links & Contacts** and **Go to Blue Cross Blue Shield Member Site**. Use the information on your member ID card to complete the process. Click the **Doctors & Hospitals** tab to conduct a personalized search based on your health plan and network.
- You can use Provider Finder from your phone or tablet by downloading the free mobile app. Just text* **BCBSTXAPP** to **33633**.
- Call Customer Service at **855-357-5228** for help.

In an emergency, call 911 or go to the nearest emergency room.

https://mybenefits.county.org

Call Customer Service at **855-357-5228** if you have a question about your benefits or want help using Provider Finder.

*Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.

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BlueCross BlueShield of Texas

Texas Association of Counties Health and Employee Benefits Pool

DO YOU WANT TO SAVE MONEY THIS YEAR?

It pays to be a smart health care shopper.

At the start of each plan year, your deductible and out-of-pocket limits start again, so it pays to know what those limits are. It is also smart to know about your costs for doctor visits and medical procedures. These can differ greatly even in the same city. Use your money wisely this year.

Terms you should know to get the most from your health plan:

- **Network:** Not all health care professionals are in the same network, so you need to check to make sure your doctor or hospital is in your plan's network.
- **Deductible:** Most plans call for you to pay a certain amount before your health plan starts to pay. For instance, if your deductible is $2,000, your plan may not pay anything until you've paid the first $2,000.
- **Coinsurance:** Some plans don't cover all your costs. They may include coinsurance - your share of the costs of a covered health care service. Coinsurance is often a percentage of the total cost. For instance, you may pay 20 percent of an allowed service while your plan pays 80 percent.
- **Copayment (or copay):** This is a flat dollar amount you pay when you see a doctor, use medical services or fill a prescription.
- **Out-of-Pocket Maximum:** Your health plan will have a limit on how much you are required to pay in one year. If your out-of-pocket maximum is $5,000, you won't pay anything once you've paid that $5,000. That means no more copays or coinsurance.

728784.0916

BlueCross BlueShield of Texas

Understand Your Health Plan Before You Get Care to Help Avoid Higher Costs.

Preauthorization (also known as 'prior authorization') means that approval is needed from your health plan before you have certain health tests or services. To help make sure your care is appropriate and to avoid unexpected costs, it's important that approval is received **before** you get these services.

Usually, your network provider will take care of preauthorization before the service is performed. But it is always a good idea to check if your doctor has gotten the needed approval.

Your Preauthorization Checklist

Once your health plan coverage starts, you can begin using the resources below. Be a smart health care shopper – use these tools to stay informed about your plan benefits!

1 CONNECT WITH US

Use the information on your Blue Cross and Blue Shield of Texas (BCBSTX) member ID card to create a Blue Access for Members℠ (BAM℠) account at https://mybenefits.county.org. Click on *Benefits*, then select *Links & Contacts* and *Go to Blue Cross Blue Shield Member Site*. Use the information on your member ID card to complete the process. And download the BCBSTX App at the Apple or Google Play store. Both tools can help you keep up with your benefits. You may also call the Customer Service number on the back of your member ID card.

2 KNOW WHAT YOUR PLAN REQUIRES

Log in to BAM and click *My Coverage*. Under the *Referral and Prior Authorization Information* tab, you'll see a list of services that may require preauthorization. You can find a more detailed list of services that require approval under your plan in your benefit booklet. Confirm with your provider that they have gotten approval before your service.

3 TRACK YOUR STATUS

You can check whether your preauthorization has been submitted or approved online. In BAM, go to *My Coverage*, then *Referral and Prior Authorization Information*. Or in the BCBSTX App, click *More*, then *Prior Authorization*.

We want you to get the most out of your health care benefits – let us help!
Call the number on the back of your BCBSTX member ID card for questions.

Services That May Require Preauthorization

We want you to be clear about what your health plan covers.

Here is a list of services[1] that may need approval in advance:

- Advanced imaging
- Air ambulance (for non-emergencies)
- Behavioral health care, either in or outside of a hospital
- Certain cardiology diagnostic, imaging and surgical procedures
- Electrical stimulation of the brain, nerves or stomach
- Home health care
- Home infusion
- Hospice
- Inpatient hospital stays[2]
- Joint surgery
- Pain management
- Sleep studies
- Some ear, nose or throat services, such as bone conduction hearing aids, cochlear implants or surgery
- Some high-cost specialty drugs
- Some surgeries of the face, jaw, mouth or teeth
- Some wound care services, such as high-pressure oxygen treatment
- Spine surgery
- Stays in a facility for rehabilitation, long-term care or skilled nursing care

You are responsible for calling BCBSTX if you get out-of-network care. Be sure to notify BCBSTX within two days of an emergency, maternity, mental health or substance abuse hospital admission at an out-of-network facility.

For preauthorization or other questions, call the number on the back of your member ID card.

1 Preauthorization requirements vary by plan. Check your benefits booklet or call the Customer Service number on the back of your member ID card for questions about your benefits.

2 In-network inpatient hospitals are required to request preauthorizations on your behalf.

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BlueCross BlueShield of Texas

Understanding Your Explanation of Benefits

An Explanation of Benefits (EOB) is a notification provided to members when a health care benefits claim is processed by Blue Cross and Blue Shield of Texas (BCBSTX). The EOB shows how the claim was processed. The EOB is not a bill. Your provider may bill you separately.

THE EOB HAS THREE MAJOR SECTIONS:

- Subscriber Information and Total of Claim(s) includes the member's name, address, member ID number and group name and number. The Total of Claims table shows you the amount billed, any applied discounts, reductions and payments and the amount you may owe the provider.
- Service Detail for each claim includes:
  - Patient and provider information
  - Claim number and when it was processed
  - Service dates and descriptions
  - The amount billed
  - The discounts or other reductions subtracted from amount billed
  - Total amount covered
  - The amount you may owe (your responsibility)
- Summary - Shows you what the plan covers for each claim and your responsibility including:

Plan Provisions

- The amount covered
- Less any amounts you may owe, like deductible, copay and coinsurance

Your Responsibility

- Deductible and copay amount
- Your share of coinsurance
- Amount not covered, if any
- Amount you may owe the provider. You may have paid some of this amount, like your copay, at the time you received the service.

THE EOB MAY INCLUDE ADDITIONAL INFORMATION:

- Amounts Not Covered will show what benefit limitations or exclusions apply.
- Out-of-Pocket Expenses will show an amount when a claim applies toward your deductible or counts toward your out-of-pocket expenses.
- Fraud Hotline is a toll-free number to call if you think you are being charged for services you did not receive or if you suspect any fraudulent activity.
- An explanation of your right to appeal if your health plan doesn't cover a health care claim.

Available in English and Spanish

Your EOBs Are Available Online!

Sign up for Blue Access for Members℠ (BAM℠) at **https://mybenefits.county.org** for convenient and confidential access to your claim information and history. Click on **Benefits**, then select **Links & Contacts** and Go to **Blue Cross Blue Shield Member Site**. Use the information on your member ID card to complete the process. Choose to opt out of receiving EOBs by mail to save time and resources. Go to BAM and click on **Settings/Preferences** to change your preferences.

https://mybenefits.county.org

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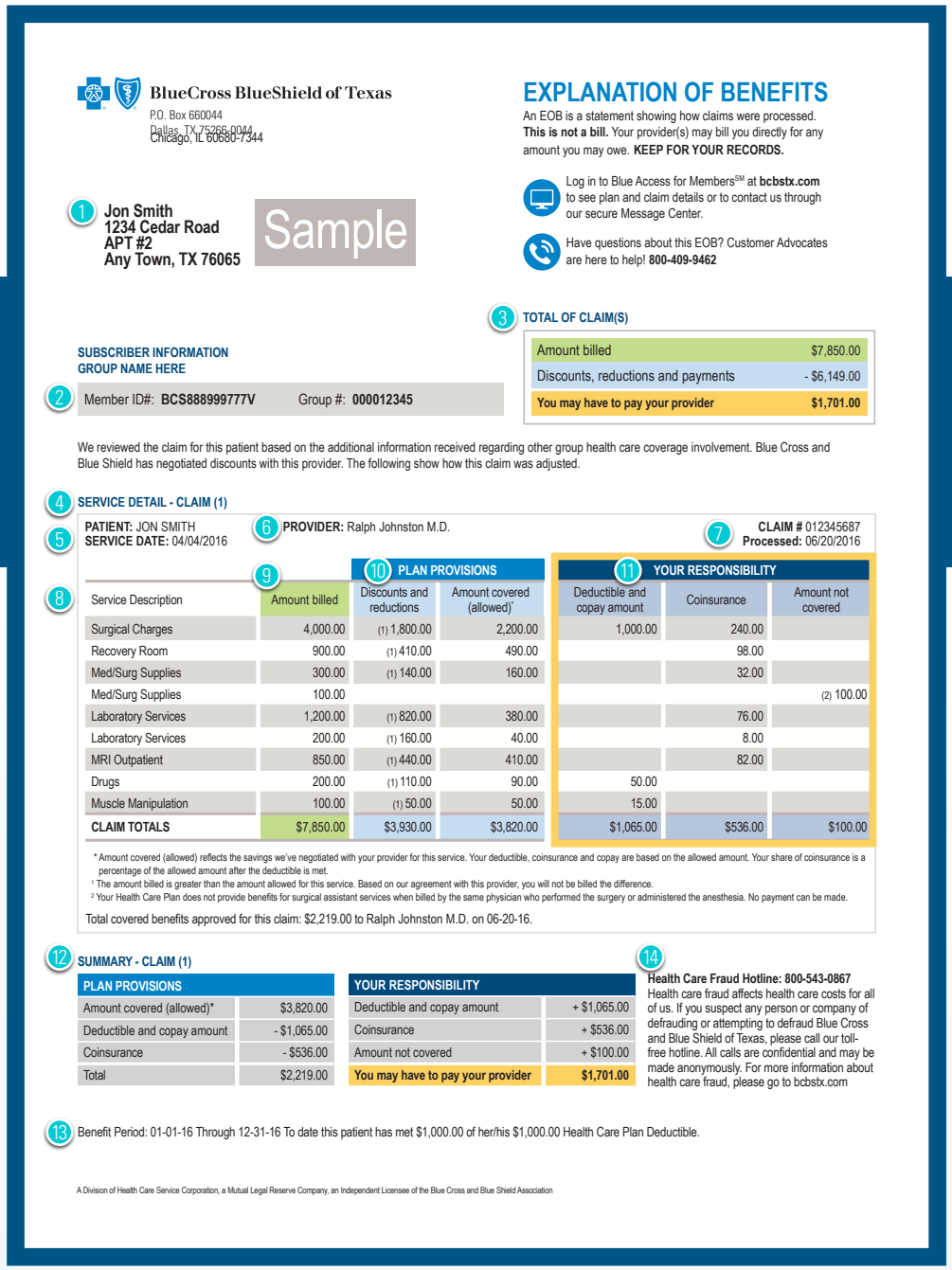
Sample EOB



BlueCross BlueShield of Texas
P.O. Box 660044
Dallas, TX 75266-0044
Chicago, IL 60680-7344

EXPLANATION OF BENEFITS

An EOB is a statement showing how claims were processed. **This is not a bill.** Your provider(s) may bill you directly for any amount you may owe. **KEEP FOR YOUR RECORDS.**

Log in to Blue Access for Members℠ at **bcbstx.com** to see plan and claim details or to contact us through our secure Message Center.

Have questions about this EOB? Customer Advocates are here to help! **800-409-9462**

1 **Jon Smith**
1234 Cedar Road
APT #2
Any Town, TX 76065

Sample

3 **TOTAL OF CLAIM(S)**

Amount billed	$7,850.00
Discounts, reductions and payments	- $6,149.00
You may have to pay your provider	**$1,701.00**

SUBSCRIBER INFORMATION
GROUP NAME HERE

2 Member ID#: **BCS888999777V** Group #: **000012345**

We reviewed the claim for this patient based on the additional information received regarding other group health care coverage involvement. Blue Cross and Blue Shield has negotiated discounts with this provider. The following show how this claim was adjusted.

4 **SERVICE DETAIL - CLAIM (1)**

5 **PATIENT:** JON SMITH
SERVICE DATE: 04/04/2016

6 **PROVIDER:** Ralph Johnston M.D.

7 **CLAIM #** 012345687
Processed: 06/20/2016

8 Service Description	9 Amount billed	10 PLAN PROVISIONS: Discounts and reductions	10 PLAN PROVISIONS: Amount covered (allowed)*	11 YOUR RESPONSIBILITY: Deductible and copay amount	11 YOUR RESPONSIBILITY: Coinsurance	11 YOUR RESPONSIBILITY: Amount not covered
Surgical Charges	4,000.00	(1) 1,800.00	2,200.00	1,000.00	240.00	
Recovery Room	900.00	(1) 410.00	490.00		98.00	
Med/Surg Supplies	300.00	(1) 140.00	160.00		32.00	
Med/Surg Supplies	100.00					(2) 100.00
Laboratory Services	1,200.00	(1) 820.00	380.00		76.00	
Laboratory Services	200.00	(1) 160.00	40.00		8.00	
MRI Outpatient	850.00	(1) 440.00	410.00		82.00	
Drugs	200.00	(1) 110.00	90.00	50.00		
Muscle Manipulation	100.00	(1) 50.00	50.00	15.00		
CLAIM TOTALS	$7,850.00	$3,930.00	$3,820.00	$1,065.00	$536.00	$100.00

* Amount covered (allowed) reflects the savings we've negotiated with your provider for this service. Your deductible, coinsurance and copay are based on the allowed amount. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.
[1] The amount billed is greater than the amount allowed for this service. Based on our agreement with this provider, you will not be billed the difference.
[2] Your Health Care Plan does not provide benefits for surgical assistant services when billed by the same physician who performed the surgery or administered the anesthesia. No payment can be made.

Total covered benefits approved for this claim: $2,219.00 to Ralph Johnston M.D. on 06-20-16.

12 **SUMMARY - CLAIM (1)**

PLAN PROVISIONS	
Amount covered (allowed)*	$3,820.00
Deductible and copay amount	- $1,065.00
Coinsurance	- $536.00
Total	$2,219.00

YOUR RESPONSIBILITY	
Deductible and copay amount	+ $1,065.00
Coinsurance	+ $536.00
Amount not covered	+ $100.00
You may have to pay your provider	**$1,701.00**

14 **Health Care Fraud Hotline: 800-543-0867**
Health care fraud affects health care costs for all of us. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Texas, please call our toll-free hotline. All calls are confidential and may be made anonymously. For more information about health care fraud, please go to bcbstx.com

13 Benefit Period: 01-01-16 Through 12-31-16 To date this patient has met $1,000.00 of her/his $1,000.00 Health Care Plan Deductible.

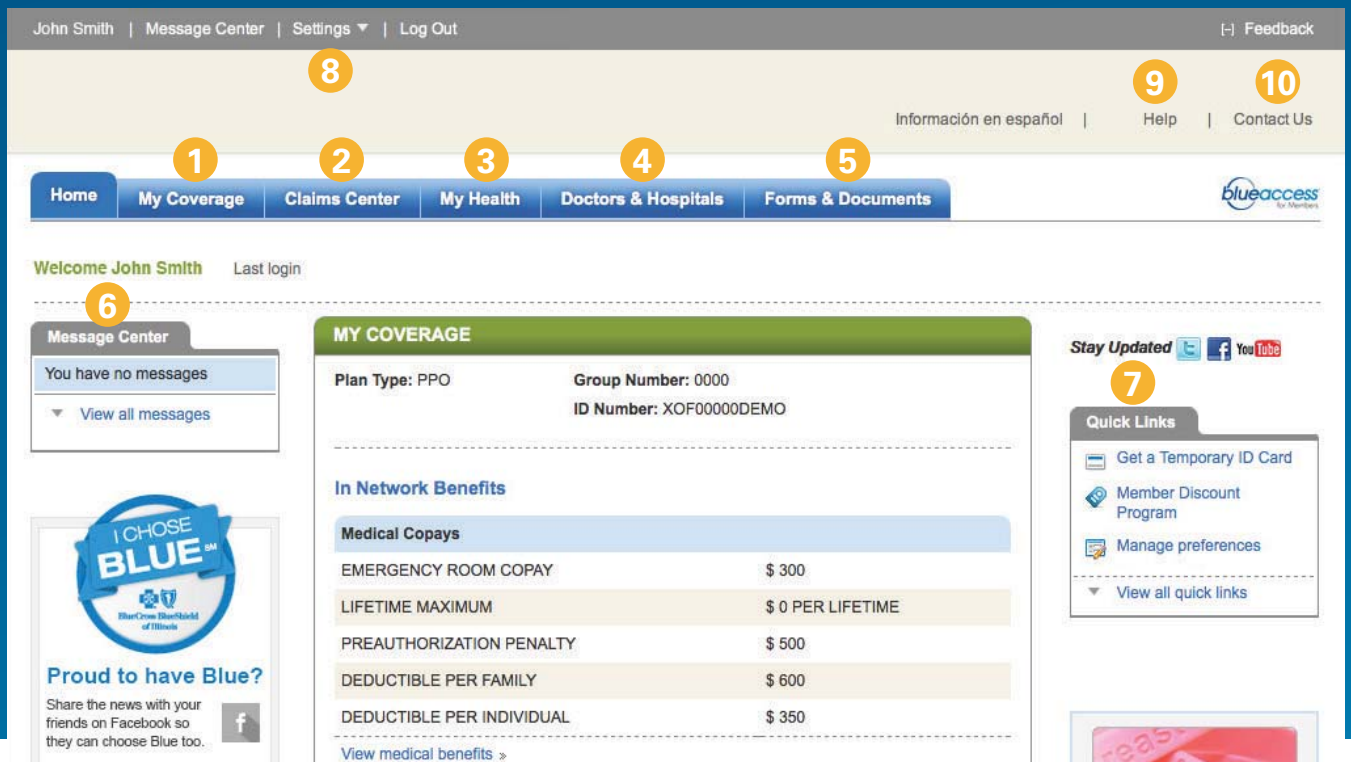
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

1. Member's name and mailing address
2. Member ID and group number
3. Summary box for all claims including total billed by the provider, and discounts, reductions or payments made, and the amount you may owe
4. Detailed claim information for each claim
5. Patient name and service date
6. Provider information
7. Claim number and date the claim was processed
8. Service description
9. Amount billed for each service
10. The amount covered (allowed) for each service and the discounts or reductions subtracted from the amount your provider billed
11. Your share of the costs
12. Claim summary with amount covered less your responsibility
13. Deductible and/or out-of-pocket expense information
14. Health Care Fraud Hotline

* Please provide this information when contacting us about a claim.

Not all EOBs are the same. The format and content of your EOB depends on your benefit plan and the services provided. Deductible and copayment amounts vary.

Find what you need with Blue Access for Members



1. **My Coverage:** Review your benefit details.
2. **Claims Center:** View and organize details such as payments, dates of service, provider names, claims status and more.
3. **My Health:** Make more informed health care decisions by reading about health and wellness topics and researching specific conditions.
4. **Doctors & Hospitals:** Use Provider Finder® to locate a network doctor, hospital or other health care provider and get driving directions.
5. **Forms & Documents:** Use the form finder to get medical, dental, pharmacy and other forms quickly and easily.
6. **Message Center:** Learn about updates to your benefit plan and receive promotional information via secure messaging.
7. **Quick Links:** Go directly to some of the most popular pages, such as medical coverage, replacement ID cards, manage preferences and more.
8. **Settings:** Set up notifications and alerts to receive updates via text and email, review your member information and change your secure password at any time.
9. **Help:** Look up definitions of health insurance terms, get answers to frequently asked questions and find Health Care School articles and videos.
10. **Contact Us:** Submit a question and a Customer Advocate will respond by phone or through the Message Center.

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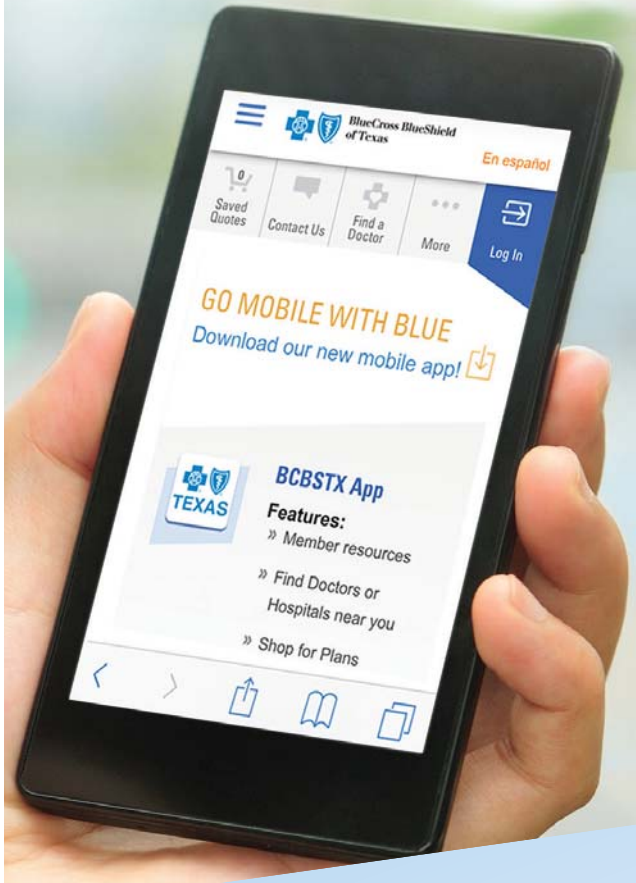
BlueCross BlueShield of Texas



Blue Access Mobile℠

allows you to conveniently and securely access your health coverage and wellness information via your mobile devices anywhere, anytime.

BCBSTX App and Mobile Website:

- Find a doctor, hospital or urgent care facility or search for Spanish-speaking providers
- Register or log in to Blue Access for Members℠
  - View coverage details
  - Check claims status
  - Access ID card information

Centered App for iPhone®:

- Promote wellness through mindful meditation and activity
  - Set a daily steps goal and a weekly meditation goal
  - Choose from three meditation sessions - short, mindful or body awareness
  - Record activity automatically

Text Messaging:

- Set up personalized, daily reminders to take your prescriptions, multi-vitamins or check your blood glucose
- Get weekly diet, exercise and fitness tips
- Send texts to BCBSTX when you need instant account information

Learn more about Blue Access Mobile at bcbstx.com/mobile or text* GOTX to 33633.

*Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.

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BlueCross BlueShield of Texas

Texas Association of Counties Health and Employee Benefits Pool

Health Insurance Fraud

What You Should Know

Fraud Affects Everyone

Fraud may cost the health care industry (public and private payers) more than $200 billion each year. As a member of Blue Cross and Blue Shield of Texas (BCBSTX), this fraud may cause you to face rising premiums, increased copayments and deductibles, and the elimination of certain benefits.

Don't Be a Victim

In addition to losing money through fraud, members may also experience physical and mental harm as a result of health care fraud schemes in which a provider performs unnecessary or dangerous procedures.

Identifying Fraud

Commonly identified schemes involving providers include:

- **Misrepresenting Services** – Intentionally billing procedures under different names or codes to obtain coverage for services that aren't included in a member's plan.
- **Upcoding** – Deliberately charging for more complex or more expensive services than those actually provided.
- **Non-rendered and/or "Free" Services** – Some providers intentionally bill for tests or services never provided. This can also mean that the provider offered "free" services to bill the insurance company for services not performed or needed.
- **Kickbacks, Bribes or Rebates** – Referring patients to a provider or facility where the referring provider has a financial interest.

Commonly identified member schemes include:

- **Identity Swapping** – Allowing an uninsured individual to use your insurance card.
- **Identity Theft** – Using false identification to gain employment and the health insurance benefits that come with it.
- **Non-eligible Members** – Adding someone to a policy who is not eligible or failing to remove someone when that person becomes ineligible.
- **Prescription Medicine Abuse and Diversion** – Controlled substances can be obtained through deception or dishonesty for personal use or sale "on the street." Prescription medications can be obtained through doctor shopping, visiting several emergency rooms or stealing doctors' prescription pads.

Fraud **increases costs** and **decreases benefits**.

Fighting Fraud

BCBSTX offers these tips:

- Know your own benefits and scope of coverage.
- Review all Explanation of Benefits (EOB) forms. Make sure the exams, procedures and tests billed were the ones you actually had with the provider who treated you.
- Understand your responsibility to pay deductibles and copayments, and what you can and cannot be balance-billed for once your claim has been processed.
- Guard your health insurance card and personal insurance information. Notify BCBSTX immediately if your card or insurance information is lost or stolen.
- Sign and date only one claim form per office visit.
- Never lend your member ID card to another person.
- Don't give out insurance or personal information if services are offered as "free." Be sure you understand what is "free" and what you or your employer will be charged for.
- Ask your doctors exactly what tests or procedures they want you to have and why. Ask why the tests or procedures are necessary before you have them.
- Be sure any referrals you receive from your network provider are to other network doctors or facilities. If you're not sure, ask.
- Monitor your prescription utilization via the BCBSTX website or your Pharmacy Benefit Manager (PBM). Make sure the medications billed to your insurance are accurate.

Our Special Investigations Department is one of the most effective in the industry.

Preventing Health Care Fraud

BCBSTX created the Special Investigations Department (SID) to fight fraud and help lower health care costs. The staff includes individuals with medical, insurance and law enforcement backgrounds as well as data analysts experienced in detecting fraudulent billing schemes. The SID aggressively investigates allegations of fraud and refers appropriate cases for criminal prosecution.

Fraud Isn't Fair. Help Us Fight It.

Reducing health care fraud is a collaborative effort between BCBSTX, its providers and its members. Additional information — including a fighting fraud checklist — is available through the SID website at *bcbstx.com/sid*.

We also encourage you to report any suspected incidence of fraud by calling our Health Care Fraud Hotline, completing a form online or sending us a note in the mail. Suspicions of fraud can be reported to the SID anonymously.

Three Ways To Report Fraud To BCBSTX

The SID is here to help you. You can contact the SID in any of the following ways:

1. **800-543-0867**
   The toll-free Fraud Hotline operates 24 hours a day, seven days a week. You can remain anonymous or provide information if you want to be contacted by a member of the SID.
2. **bcbstx.com/sid/reporting**
   This website address links to an online fraud reporting form that can be completed and sent to the SID electronically.
3. **U.S. Mail**
   You can write the SID at:
   Blue Cross and Blue Shield of Texas
   Special Investigations Department
   1001 E. Lookout Drive, Tower A-2.212
   Richardson, Texas 75082

50638.0814

Medical Plan Frequently Asked Questions

Q. Are my medical records kept confidential?

A. Yes. Blue Cross and Blue Shield of Texas (BCBSTX) is committed to keeping all specific member information confidential. Anyone who may have to review your records is required to keep your information confidential. Your medical records or claims data may have to be reviewed (for example, as part of an appeal that you request). If so, precautions are taken to keep your information confidential. In many cases, your identity will not be associated with this information.

Q. Who do I call with questions about my benefits?

A. Call the toll-free Customer Service number on the back of your ID card.

Q. How do I find a contracting network doctor or hospital?

A. Go to **bcbstx.com** and use the **Provider Finder®**, or call Customer Service at the toll-free number on the back of your ID card.

Q. What do I do when I need emergency care?

A. Call 911 or seek help from any doctor or hospital. BCBSTX will coordinate your care with the emergency provider.

Q. What should I bring to my first appointment with a new doctor?

A. Your first appointment is an opportunity to share information about your health with your new doctor. Bring as much medical information as possible, including:

- **Medical records and insurance card** — If you are undergoing treatment at the time you change doctors, your medical records are important to your new doctor. Your insurance card provides information about copayments, billing and customer service phone numbers.
- **Medications** — Give your new doctor information about prescription and over-the-counter medications, including any herbal medications you take. Be sure to include the name of the medication, the dosage, how often you take it and why you take it.
- **Special needs** — Make a list of any equipment or devices you use including wheelchairs, oxygen, glucose monitors and the glucose strips. Be prepared to explain how you use them, not only to make sure you have the equipment you need, but also to make sure that there is no disruption in your care.

Q. What questions should I ask if I am selecting a new doctor?

A. In addition to preliminary questions you might ask a new doctor — such as "Are you accepting new patients?" — here are some questions to help you evaluate whether a doctor is right for you.

- What is the doctor's experience in treating patients with the same health problems that I have?
- Where is the doctor's office? Is there convenient and ample parking, or is it close to public transportation?
- What are the regular office hours? Does the office have drop-in hours if I have an urgent problem?
- How long should I expect to wait to see the doctor when I'm in the waiting room?
- Are routine lab tests and X-rays performed in the office, or will I have to go elsewhere?
- Which hospitals does the doctor use?
- If this is a group practice, will I always see my chosen doctor?
- How long does it usually take to get an appointment?
- How do I get in touch with the doctor after office hours?
- Can I get advice about routine medical problems over the phone or by email?
- Does the office send reminders for routine preventive tests like cholesterol checks?

Q. What if I'm already in treatment when I enroll and my provider isn't in the network?

A. We'll work with you to provide the most appropriate care for your medical situation, especially of you are pregnant or receiving treatment for a serious illness. You may still be able to see your out-of-network provider for a period of time. Call the toll-free Customer Service number on the back of your ID card for more information.

BlueCross BlueShield of Texas

Texas Association of Counties Health and Employee Benefits Pool

Your Medicare Checklist:

This checklist will help you remember the important steps that need to be taken between now and your 65th birthday or when you become Medicare eligible. The items are listed in the order you should address them.

7 to 9 Months Before Your 65th Birthday

- ☐ Contact the Social Security Administration at 1-800-772-1213, TTY: 1-800-325-0778, or go online to ssa.gov to confirm your eligibility for Medicare benefits.
- ☐ Review your current health insurance coverage to find out what happens after you become Medicare eligible. If you are working, contact your Human Resources department.

4 to 6 Months Before Your 65th Birthday

- ☐ Check with your current doctors to see if they accept Medicare.
- ☐ Learn and research Medicare coverage options in your area at medicare.gov (general Medicare information, ordering Medicare booklets, information about health plans, learning if you qualify for financial assistance) or bcbstx.com/medicare (coverage specifics, plan options and estimated costs).

3 Months Before Your 65th Birthday

- ☐ Enroll in Medicare Part A and Part B*. If you haven't received your automatic enrollment packet in the mail, contact the Social Security Administration at 1-800-772-1213, TTY/TDD: 1-800-325-0778, or go online to ssa.gov.
- ☐ Select your Medicare coverage option. Learn about BCBSTX's options at bcbstx.com/medicare or speak to a BCBSTX Medicare sales representative at 1-866-292-6745, TTY/TDD: 711. We are open 8 a.m. – 8 p.m., local time, 7 days a week. If you are calling from February 15 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

* You may defer enrollment in Part B for as long as you are enrolled in a qualifying group health plan.

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IV.
Navitus - Prescription Drugs

FINDING YOUR PHARMACY

Navitus makes it easy to fill your prescriptions with retail network pharmacies around the United States. Choose a participating retail pharmacy close to home or work.

Some of the pharmacies available:

- CVS
- HEB
- Lifechek
- Walgreens
- WalMart
- Kroger
- Brookshire Brothers
- Savon
- plus many independently operated retail pharmacies

NOTE: Not all retail stores for pharmacy chains listed above are included in the network. Check the up-to-date listing on the website or call Navitus Customer Care to confirm that your preferred pharmacy is a participating network location.

If you are taking a maintenance medication for longer than 30 days, consider using the mail order pharmacy or participating '90 day at retail' pharmacy locations. It's convenient and saves money.

QUESTIONS?

NAVITUS CUSTOMER CARE

1-866-333-2757

Open 24 hours a day, 7 days a week.

Or visit us online at: www.mybenefits.county.org

N3684-0911

NAVITUS
PHARMACY BENEFITS REINVENTED™

COMPARE PRICES AND LOCATE PHARMACIES USING NAVITUS' COST COMPARE TOOL

Are you looking for ways to pay the lowest cost for your medications? Navitus can help.

Prescription medication prices often vary between pharmacies. To help you compare prescriptions costs and choose the best price at the best location, Navitus offers Cost Compare.

The Cost Compare tool is available via the Navi-Gate® for Members portal through www.mybenefits.county.org. This new tool can help you:

- Identify lower cost alternatives
- See suggested alternatives to your prescribed drugs
- Find participating network pharmacies

By entering information such as your city and state or zip code, the name and strength of your prescribed drug, and other preferences, the Cost Compare tool will provide results that allow you to compare prices and save on your prescriptions.

Cost Compare is available on **any device, anywhere, anytime**, and at no additional cost.

Compare pharmacy prices in your area

Get real-time, accurate prices estimates

Search based on your prescription history

QUESTIONS?

NAVITUS CUSTOMER CARE

1-866-333-2757

Open 24 hours a day, 7 days a week.

Or visit us online at: www.mybenefits.county.org

NAVITUS
PHARMACY BENEFITS REINVENTED™

N5139-0217

SAVING MONEY
with mail order service

WHY USE OUR MAIL SERVICE?

With Navitus' mail order pharmacy service through Costco, you save both money and time spent picking up your medicine. By filling your prescriptions through mail order, you may receive a 3-month supply of medication for the out-of-pocket costs of 2 months.* *You do not have to be a member of Costco to use the mail order service.*

* Please refer to your plan description for more details.

Drug	Supply	Copay Amount	Out of Pocket Costs per Year
Glipizide	30 days	$5.00	$60.00
Glipizide	90 days	$10.00	$40.00

With this example, total cost savings is $20.00 a year!

*drug costs are for example only

NAVITUS CUSTOMER CARE
1-866-333-2757

Open 24 hours a day, 7 days a week.

Or visit us online at: www.mybenefits.county.org

N3685-0911

FILLING YOUR PRESCRIPTION

Filling Your Prescription at a Network Pharmacy	The first step to filling your prescription is deciding on a participating pharmacy. In most cases, you can still use your current pharmacy. There is a complete list on the Navitus member website.
Your Pharmacy Benefit ID Card	Your TAC HEBP/Blue Cross ID card contains information the pharmacy needs to process your prescription. To determine your copay before going to the pharmacy, consult your Pharmacy Benefit Highlights or call customer care.

Submitting a Claim

In an emergency, you may need to request reimbursement for prescriptions that you have filled and paid for yourself. To submit a claim, you must provide specific information about the prescription, the reason you are requesting reimbursement, and any payments made by primary insurers. Complete the appropriate claim form and mail it along with the receipt to:

Navitus Health Solutions Operations Division - Claims P.O. Box 999, Appleton, WI 54912-0999

Claim forms are available on the website or by calling customer care.

Understanding Your Prescription Label

NAVITUS HEALTH SOLUTIONS

Medication labels can be confusing and hard to read and it's easy to forget a doctor's or pharmacist's instructions. This handy guide makes it easy to decipher the prescription label on your medication, so you can take your medication correctly and reap the benefits of improved health.

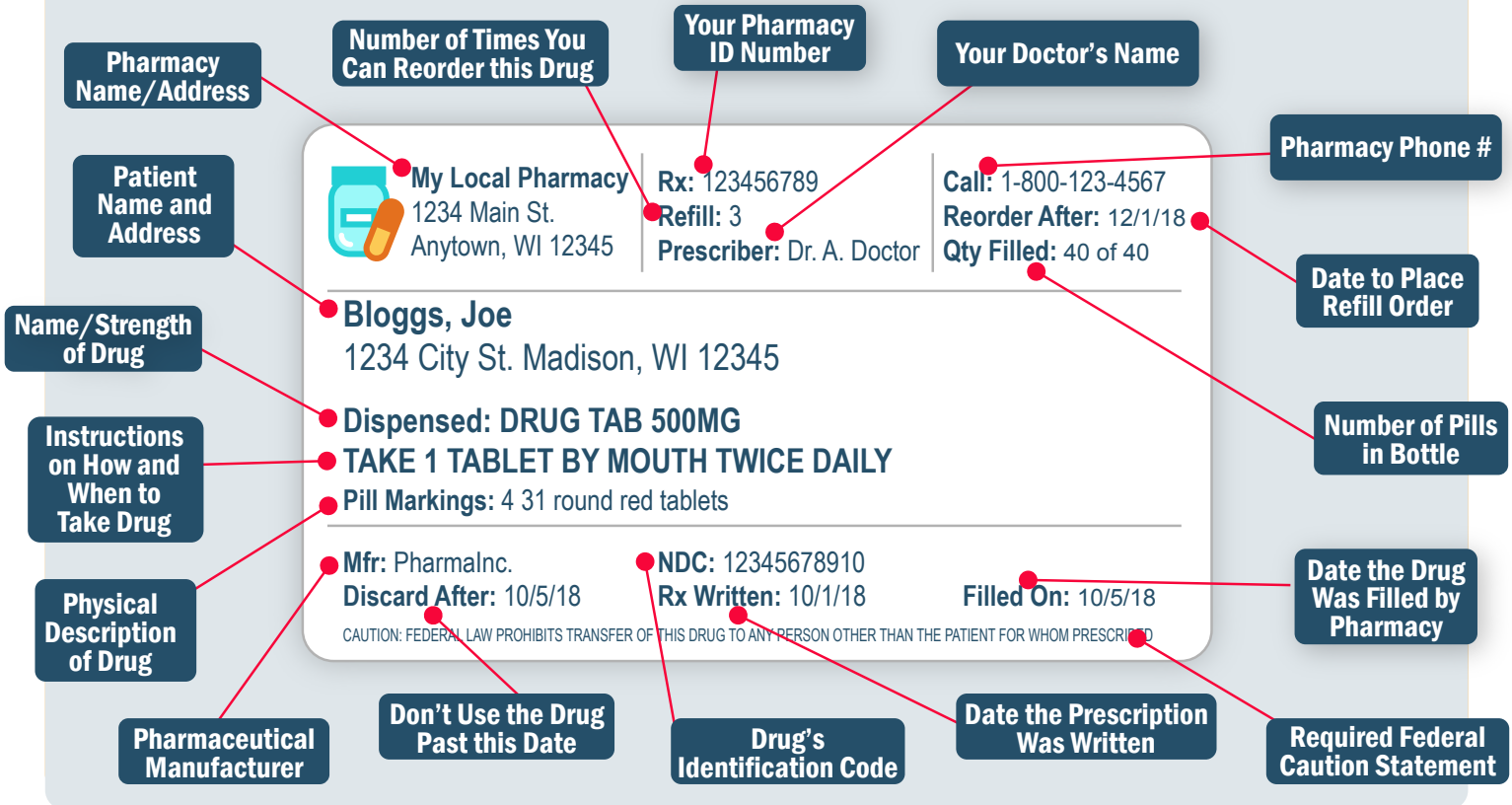
Why Is This Important?

500,000 harmful side effects occur outside the hospital every year[1]

25% caused by name confusion[2]

33% caused by packaging & labeling confusion[2]

Not all prescription labels look alike, but this example shows the key features that most labels will have.



[1] Aspden P, Wolcott J, Bootman L, Cronenwett L, editors. Preventing medication errors. Washington DC: Institute of Medicine of the National Academies; 2006.
[2] Berman A. Reducing medication errors through naming, labeling, and packaging. J Med Syst. 2004;28:9–29.

Reading Label Instructions

78% of patients misunderstood one or more label instructions.[3]

Here are some common instructions and what they mean. If in doubt, always ask your pharmacist.

What it says:	What it means:
Take 3 tablets by mouth twice daily.	Take 3 tablets every 12 hours.
Take 2 pills by mouth every day. Take 1 with Breakfast and 1 with dinner.	Take 1 pill with breakfast and take 1 pill with dinner every day. These should be around 12 hours apart.
Take 1 tablet by mouth three times daily.	Take 1 tablet every 8 hours.

Five Things to Check at the Pharmacy

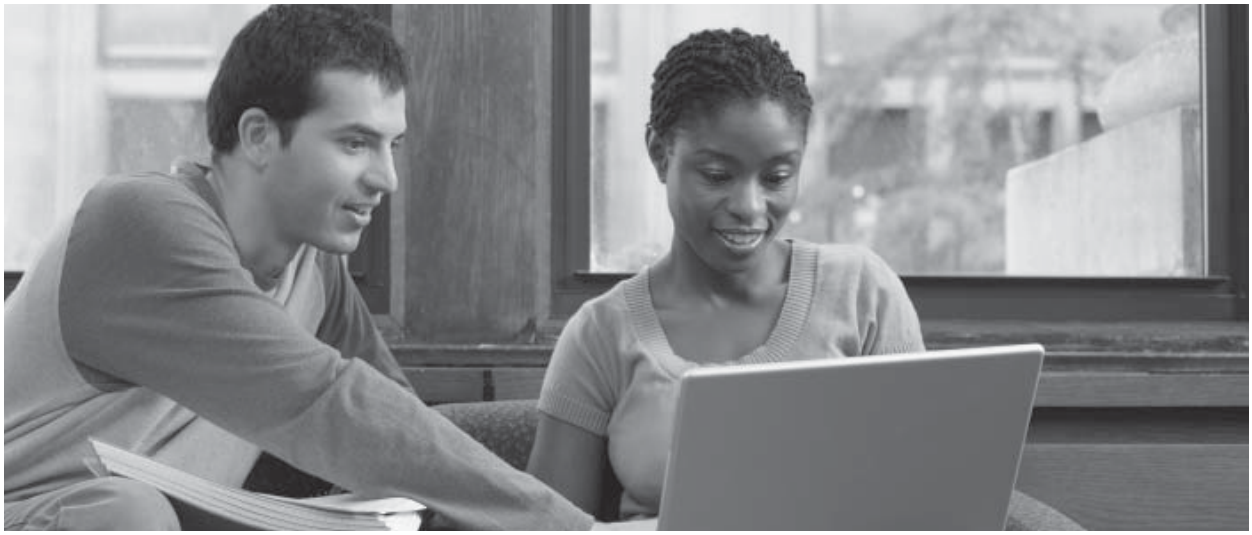
1. Is the medication correct?
2. Is the dosage correct?
3. Do I understand the instructions?
4. When does it expire?
5. How do I get refills?

Five Questions to Ask Your Pharmacist

1. How much should I take, when, and how often?
2. Does my medication interact with other medications I'm taking?
3. Is there anything I should avoid eating or drinking while taking my medication?
4. What are the possible side effects?
5. When should I stop taking this medication?

[3]Davis TC, Federman AD, Bass PF, III, et al. Improving patient understanding of prescription drug label instructions. J Gen Intern Med. 2009;24:57–62.

FORMULARY FACTS



About Drug Formularies

The formulary is a comprehensive list of preferred drugs chosen on the basis of quality and efficacy by a committee of physicians and pharmacists. The drug formulary serves as a guide for the provider community by identifying which drugs are covered. It is updated regularly and includes brand name and generic drugs.

Selecting Drugs for Your Formulary

An independent group of physicians and pharmacists meets regularly during the year to review and recommend drugs for your formulary that will be, effective and affordable. The committee assesses drugs based on their therapeutic value, side effects and cost compared to similar medications. Based on the committee's review of new and existing drugs, your formulary is evaluated to ensure it is up-to-date. Navitus and TAC HEBP then review these recommendations and will post updates to the formulary on our websites.

Checking Your Formulary	Your formulary is on the website through your TAC HEBP member portal, www.mybenefits.county.org. You may search the formulary for a specific drug. You can also browse alphabetically or by category of use. Also included is information about which drug products need prior authorization and/or have quantity limits. The formulary is a condensed list and does not list every covered drug. The coverage or tier for each drug product is noted on the formulary. But the dollar amount you pay for each medication is not listed. See the Pharmacy Benefit Highlights included in this booklet for more information, including the cost share amount you pay for each drug.
Changes to Your Formulary	Your formulary is evaluated on an ongoing basis, and could change. Navitus does not send separate notices if a brand-name drug becomes available as a generic drug. The pharmacist usually tells you this information when you fill your next prescription. If you have more questions about the formulary or your cost share, please contact Customer Care.

WHAT IS PRIOR AUTHORIZATION?

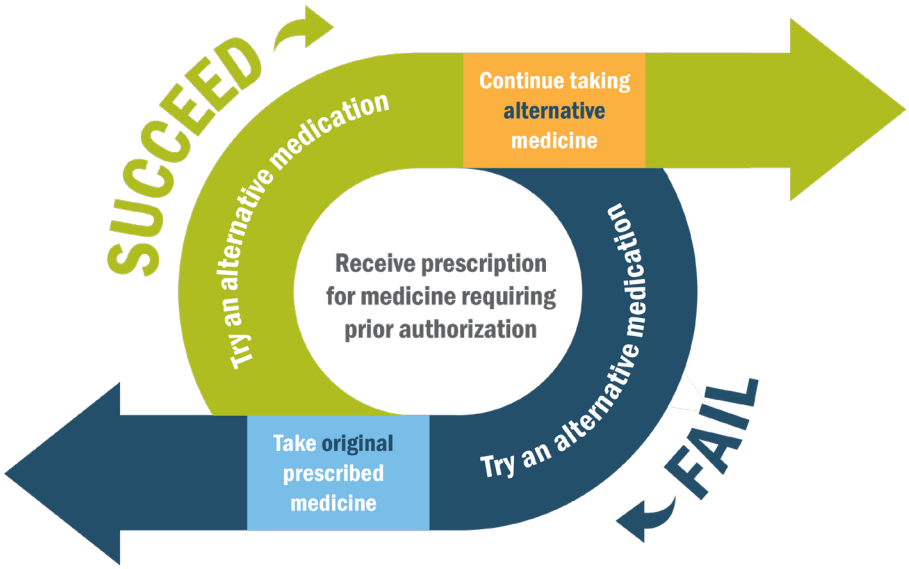
Prior authorization is a tool that ensures members receive safe, appropriate, and cost-effective medicine. Medicines requiring prior authorization are noted on your formulary with a PA.

How Does It Work?

If you are prescribed a medicine that needs prior authorization, you will need to meet certain criteria before the medicine is covered by your plan.

Before a prior authorization is approved, your prescriber will be asked to write a prescription for an alternative medicine that is covered under your plan. These alternatives have similar therapeutic value and effectiveness. If you try the alternative medicine and it does not have the intended response, the prior authorization for the original prescription can be considered. If the alternative medicine works, you will be encouraged to continue taking it.

Alternatively, your doctor may decide that you do not need to try an alternative medicine. This will be based on your diagnosis or unique situation. In this case, the prescriber, plan sponsor and Navitus will work together to complete the prior authorization process.



Who Decides What Medicines Need Prior Authorization?

Your plan sponsor works with Navitus to develop prior authorization criteria. These follow recommendations from the FDA and the Navitus Pharmacy and Therapeutics Committee.

Why Does Navitus Use Prior Authorization?

Prior Authorization is a standard health care process that most pharmacy benefit managers use. It is an effective tool for making sure that members receive the best quality medicine at the lowest cost. It is one of the many tools that support Navitus' mission to improve member health and lower costs.

N6196-0518

WHAT IS STEP THERAPY?

Step therapy is a formulary management tool used for high-cost prescription medicine. When a medicine requires Step Therapy (noted on the formulary with ST), you must try a less costly prescription medicine first. This is called a *first-line therapy*. Once you have tried and failed a first-line therapy, you will be able to take steps to receive the medicine you were originally prescribed, which is called a *second-line therapy*.

You and your prescriber may find that the first-line therapy works very well for you. If that's the case, you may continue using it rather than pursuing the second-line therapy.

If you feel that your need for a second-line therapy should override this process, please ask your prescriber to contact Navitus. And rest easy knowing that there are other covered medicines available with similar therapeutic value, effectiveness, and side effects.

Who decides what medicines need Step Therapy?
Your plan sponsor and the Navitus Pharmacy and Therapeutics Committee have worked together to decide which medicines should require Step Therapy.

Why does Navitus use Step Therapy?
Step Therapy is an effective tool for ensuring that members receive safe, effective, high-quality medicine at the lowest net cost. It is our mission to improve health among our members. Formulary management—which includes Step Therapy—is one of the many ways we can help members experience good quality of life and manageable medication regimens.

Rx FAQs

How do I fill a prescription when I travel for business or vacation?

If you are traveling for less than one month, any Navitus Network Pharmacy can arrange in advance for you to take an extra one-month supply. A copayment will apply.

Visit **www.navitus.com** for complete instructions on filling prescriptions while traveling, or contact Customer Care.

If you are traveling for more than one month, you can request that your pharmacy transfer your prescription order to another network pharmacy located in the area where you will be traveling.

Can prescriptions be mailed to me if I'm outside of the United States?

Prescriptions cannot legally be mailed from the mail order pharmacy or any pharmacy in the United States to locations outside of the country, except for U.S. territories, protectorates and military installations.

How do I use the Navitus SpecialtyRx program?

Navitus SpecialtyRx works with our specialty partner to offer services with the highest standard of care. You will get one-on-one service with skilled pharmacists. They will answer questions about side effects and give advice to help you stay on course with your treatment. With Navitus SpecialtyRx, delivery of your specialty medications is free, and right to your door or prescriber's office via FedEx. Local courier service is available for emergency, same day medication needs. We will work with your prescriber for current or new specialty prescriptions.

COMMON TERMS

Copayment/ Coinsurance	Refers to that portion of the total prescription cost that the member must pay.
Formulary	A list of drugs that are covered under your benefit plan. The drugs on your formulary are chosen for your formulary by an independent group of doctors and pharmacists. These experts evaluate drugs based on effectiveness, side-effects, potential for drug interactions, and cost. Drugs that are both clinically sound and cost effective are added to your formulary.
Generic Drugs	Prescription drugs that have the same active ingredients, same dosage form and strength as their brand name counterparts.
Out-of-Pocket Maximum	The maximum dollar amount the member can pay per contract year.
Over-the-Counter Medication	A drug you can buy without a prescription.
Prescription Drug	Any drug you may get by prescription only.
Prior Authorization	Approval from Navitus for coverage of a prescription drug.
Specialty Drug	Drugs, such as self-injectables and biologics typically used to treat patients with chronic illnesses or complex diseases.
Therapeutic Equivalent	Similar drug in the same drug classification used to treat the same condition.

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V.
Health & Wellness

BlueCross BlueShield of Texas

Here's One Call You Don't Want to Miss

If you get a call from Blue Cross and Blue Shield of Texas (BCBSTX), we're calling to help you take good care of your health. Please answer or call us back.

Your health plan includes support for you and your covered family members from nurses and other medical professionals called health advisors.* This extra help is available at no added cost to you.

BCBSTX may call to help you:

- Get the care you need for serious illnesses or injuries
- Have a healthy pregnancy and baby
- If you have been in the hospital or have had a major surgery

Calls from health advisors are not sales calls. We may ask you for information, like your name, date of birth or home address, to make sure that we are talking to you. Any information you provide to BCBSTX is confidential, as required by law.

If we miss you, ring us back. We're here for you!

* Health advisors do not replace the care of a doctor. You should talk to your doctor about any medical questions or concerns.

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BlueCross BlueShield of Texas

Wellbeing is about Progress, Not Perfection

Even small changes can help improve your health. So work on your wellbeing goals from one, simple dashboard, Blue Access for Members℠ (BAM℠). It's included with your plan. Go ahead – take your first step toward a healthier you!

Get Started Now! It's As Easy As...

1. Go to https://mybenefits.county.org.
2. Click on Benefits, then select Links & Contacts and Go to Blue Cross Blue Shield Member Site. Use the information on your member ID card to complete the process.
3. Click the My Health tab.

What You Can Do

- Access Well onTarget® to help manage your overall wellbeing:
  - Take a Health Assessment to jumpstart your wellness journey with a personal health report.[1]
  - Engage in digital self-management programs to help you reach your health and wellbeing goals.
  - Link and track your fitness devices and nutrition apps in one place.
  - Earn and redeem Blue Points℠ when you complete healthy activities.[2]
- Join the Fitness Program with access to more than 10,000 fitness locations nationwide.[3]
- Talk to a nurse 24 hours a day.[4]
- Get support from a maternity specialist throughout a pregnancy.

Resources to Help You with:

- Asthma
- Back pain
- Blood pressure
- Cholesterol
- Diabetes
- Eating healthy
- Financial wellbeing
- Heart health
- Losing weight
- Pregnancy
- Quitting smoking
- Stress

1. Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.
2. Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal at wellontarget.com for further information. Member agrees to comply with all applicable federal, state and local laws, including making all disclosures and paying all taxes with respect to their receipt of any reward.
3. A $25 enrollment fee and $25 monthly fee apply per member. Taxes may apply. Individuals must be at least 18 years old to purchase a membership.
4. For medical emergencies, call 911. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

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Galveston County - Healthy County Resources

Employees who embrace wellness experience increased productivity, improved morale and stronger workplace loyalty. An employee's healthier lifestyle translates into lower absenteeism, lower health care costs and fewer workers' compensation claims. Healthy County can help get you there.

Lifestyle Resources

Healthy County (Sonic Boom) Portal

This integrated health and physical activity portal gives you access to Healthy County wellness contests, a fitness device subsidy and the storefront, where you can find activity trackers, free health education courses and more.

ONLINE: Healthy County (Sonic Boom) Portal at www.county.org/sonicboom

Blue Points Rewards

Earn points from the Well onTarget program from Blue Cross and Blue Shield of Texas (BCBSTX) by participating in healthy activities. Redeem points for clothing, books, health and personal care, jewelry, electronics, music, sporting goods and more.

ONLINE: Employee Self-Service (ESS) Portal > My Vendors & Other Sites > Go to Blue Cross Blue Shield Member Site > Well onTarget (under Quick Links)

Health Assessment

Begin with a confidential, personalized guide to your overall health. Learn how the lifestyle choices you make today can affect you in the future and put your health at risk.

ONLINE: Employee Self-Service (ESS) Portal > My Vendors & Other Sites > Go to Blue Cross Blue Shield Member Site > Health Assessment (under Quick Links)

Gym Discount Program

Join the BCBSTX Fitness Program for unlimited access to thousands of participating fitness locations nationwide. There is a $19 one-time enrollment fee + tiered network options with prices ranging from $19 to $99 a month with no annual contract.

ONLINE: Employee Self-Service (ESS) Portal > My Vendors & Other Sites > Go to Blue Cross Blue Shield Member Site > Fitness Program (under Quick Links)

Digital Self-Managed Programs

From stress management to weight loss, nutrition, fitness and more, a Well onTarget lifestyle coach can guide you along your journey to better health.

ONLINE: Employee Self-Service (ESS) Portal > My Vendors & Other Sites > Go to Blue Cross Blue Shield Member Site > Well onTarget (under Quick Links) > Courses

Livongo®

Livongo empowers self-management of chronic conditions for individuals with diabetes. Participants who are in the Livongo for Diabetes program will receive the Livongo blood glucose meter, unlimited diabetes test strips, which are delivered on demand, and immediate interventions when blood glucose levels are dangerously high or low. Livongo health coaches provide support for questions on nutrition or lifestyle changes. All supplies are provided to the member at no cost.

ONLINE: get.livongo.com/healthycounty
REGISTRATION CODE: HEALTHYCOUNTY

Online Access

- Healthy County on the TAC website at www.county.org/healthycounty
- **Employee Self-Service (ESS) Portal** at mybenefits.county.org
  - Access to Healthy County wellness program information, the Sonic Boom wellness portal, Blue Cross and Blue Shield of Texas (BCBSTX) benefits and records, Navitus Health Solutions for prescription benefits, the Texas County & District Retirement System and more.
- **Healthy County (Sonic Boom) Portal** at www.county.org/sonicboom
  - Access to wellness contests, the fitness device storefront, activity tracking, health education courses and more.
- Follow Healthy County on Facebook at www.facebook.com/TACHealthyCounty

Healthy County
Together. Better. Stronger.
Texas Association of Counties
Health and Employee Benefits Pool

Health Management Resources

Blue Access for Members

Take charge of your health – and save time and money – with BCBSTX Blue Access for Members. Review your health and dental coverage, examine claims, find doctors and hospitals through Provider Finder,® estimate costs for a medical service, find a dentist and more.

ONLINE: Employee Self-Service (ESS) Portal > My Vendors & Other Sites > Go to Blue Cross Blue Shield Member Site

Telemedicine With MDLIVE

Conduct a virtual visit with a doctor or therapist who can provide a diagnosis and prescribe medications (when appropriate) via videoconference, mobile app or telephone 24/7. Services include general health, pediatric care and behavioral health. The cost of a MDLive visit is $10 for general health and pediatric care and $35 for behavioral health for the Base and Buy-Up Plans. Visit is subject to deductible and coinsurance for the High Deductible Health Plan (HDHP).

ONLINE: www.mdlive.com/BCBSTX
PHONE: Call (888) 680-8646

24-Hour Nurseline

Speak confidentially at no cost with an experienced registered nurse who can help with health care concerns for you and your family.

PHONE: Call (855) 357-5228; ask for Nurseline

Airrosti

Airrosti is a safe, noninvasive and highly effective alternative to surgery, pain management and long-term chiropractic or physical therapy programs. The copay is $25 for the Buy-Up Plan. The Base Plan and HDHP will be subject to deductible and coinsurance.

ONLINE: www.airrosti.com
PHONE: Call (800) 404-6050
VIRTUAL VISITS:
www.airrosti.com/RemoteRecovery

Condition Management

Confidential assistance and health coaching is available through Wellbeing Management for conditions including cancer, congestive heart failure, coronary artery disease, chronic obstructive pulmonary disease, asthma, diabetes, metabolic syndrome, high blood pressure and more.

ONLINE: Employee Self-Service (ESS) Portal > My Vendors & Other Sites > Go to Blue Cross Blue Shield Member Site > Well onTarget (under Quick Links) > Courses

Quit Tobacco

This six-week online tobacco cessation program provides personal coaching and cessation medications.

ONLINE: Employee Self-Service (ESS) Portal > My Vendors & Other Sites > Go to Blue Cross Blue Shield Member Site > Well onTarget (under Quick Links) > Courses
MEDICATIONS: For questions about covered cessation medications, call Navitus Health Solutions at (866) 333-2757

Women's and Family Health Programs

These programs focus on maternity management and parenting support. Maternity management consists of low risk maternity management support via Ovia Health, more specialized management for high risk pregnancies via Special Beginnings and a self-management program via Well onTarget.

PHONE: Call (855) 357-5228 to find out which women's and family health program is right for you.

Stay in the Know

Subscribe to the Monthly Healthy Byte E-Newsletter

For Healthy County news, challenge updates, healthy lifestyle tips and inspiring stories.
Sign up at www.county.org/HCMonthly.

Healthy County Together. Better. Stronger.
Texas Association of Counties Health and Employee Benefits Pool

BlueCross BlueShield of Texas

Well onTarget®

Live Well with the Well onTarget Member Wellness Portal

The Well onTarget Member Wellness Portal at **wellontarget.com** provides you with tools to help you set and reach your wellness goals. The portal is user-friendly, so you can find everything you need quickly and easily.

EXPLORE YOUR WELLNESS WORLD

When you log in to your portal, you will find a wide variety of health and wellness resources, including:

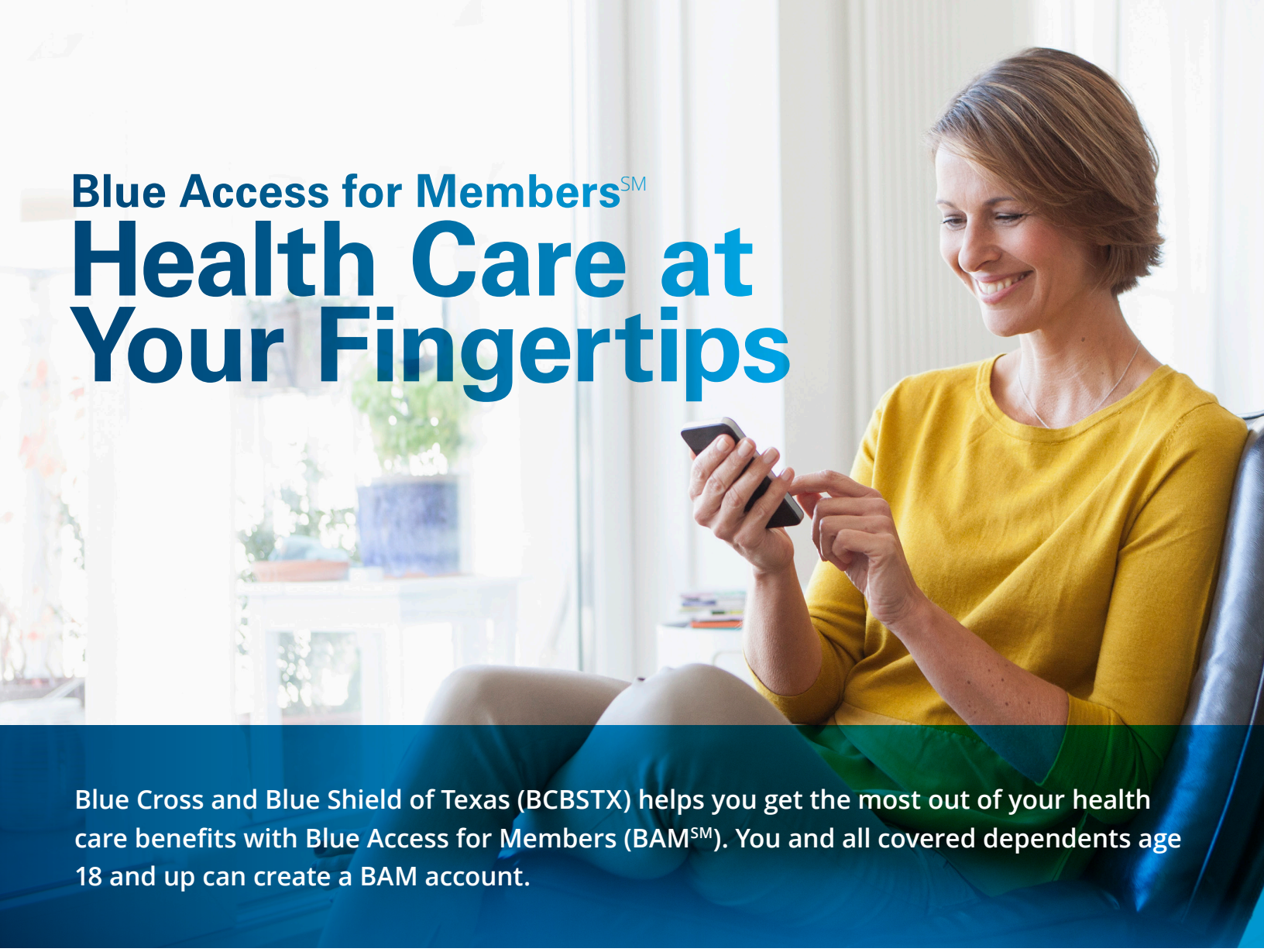
- The Health Assessment (HA)
- Self-Management Programs
- Health trackers
- Trusted news and health education content

SEE YOUR STATS IN A FLASH

Everything you want to see quickly is on your dashboard. The dashboard shows all of your Well onTarget programs. You can see where you are today compared with where you were when you started. You can also read the latest health news, check your activity progress and more.

TAKE A SNAPSHOT OF YOUR HEALTH

The HA asks you questions about your health and habits.[1] You then get a Personal Wellness Report. This report suggests ways to make positive lifestyle changes. Your report can also help you decide which Well onTarget program to start first to get the most benefit. You can even print a Provider Report to share with your doctor.



Blue Access for Members℠

Health Care at Your Fingertips

Blue Cross and Blue Shield of Texas (BCBSTX) helps you get the most out of your health care benefits with Blue Access for Members (BAM℠). You and all covered dependents age 18 and up can create a BAM account.

With BAM, you can:

- Use our Provider Finder® tool to search for a health care provider, hospital or pharmacy
- Request or print your ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Use our Cost Estimator tool to find the price of hundreds of tests, treatments and procedures
- Download our app
- Sign up for text or email alerts

It's Easy to Get Started!

1 Go to **https://mybenefits.county.org**

2 Click on **Benefits**, then select **Links & Contacts** and **Go to Blue Cross Blue Shield Member Site**

3 Use the information on your BCBSTX ID card to sign up

Or, text* **BCBSTXAPP** to **33633** to get the BCBSTX App that lets you use BAM while you're on the go.

*Message and data rates may apply.

BlueCross BlueShield of Texas

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BlueCross BlueShield of Texas

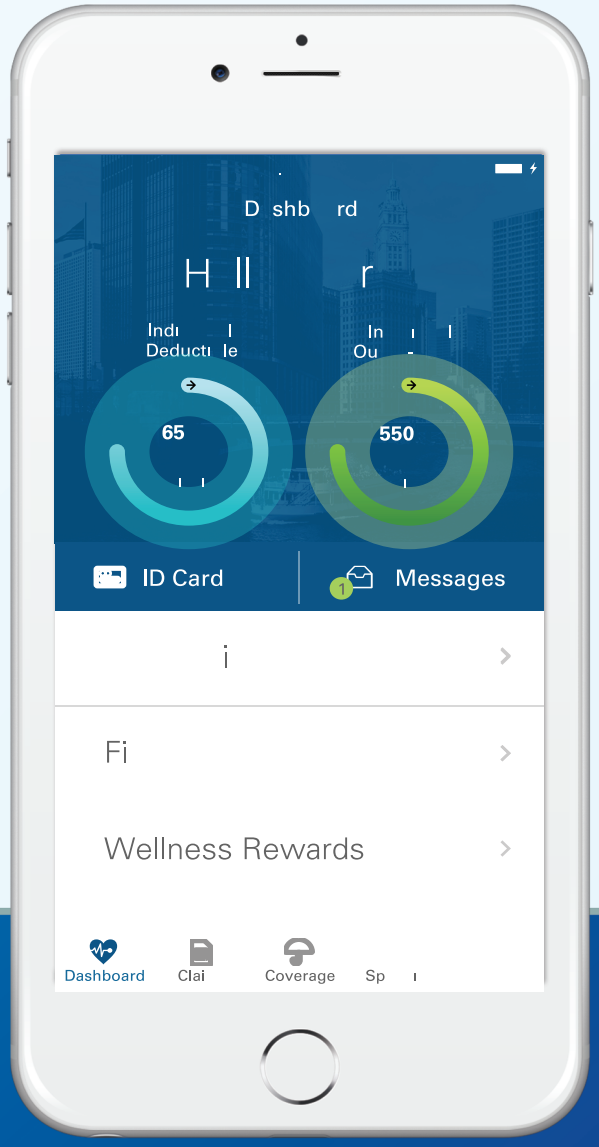
The BCBSTX App!

TEXAS

Stay connected with Blue Cross and Blue Shield of Texas (BCBSTX) and access important health benefit information wherever you are.

- Find an in-network doctor, hospital or urgent care facility
- Access your claims, coverage and deductible information
- View and email your member ID card
- Log in securely with your fingerprint
- Access Health Care Accounts and Health Savings Accounts
- Download and share your Explanation of Benefits*
- Get Push Notifications and access to Message Center*

Available in Spanish



Text** **BCBSTXAPP** to **33633** to get the app.

* Currently only available on iPhone®. iPhone is a registered trademark of Apple Inc.

** Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.

Download on the App Store

GET IT ON Google play

bcbstx.com/mobile

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BLUE POINTS℠ PROGRAM[2]

Small rewards may motivate you to make positive changes to meet your wellness goals. With Well onTarget, you can earn Blue Points for making healthy choices. If you enroll in the Fitness Program or take your HA, you earn points.[3] You can also earn points when you achieve milestones in the Self-Management Programs. Redeem your Blue Points in the online shopping mall, which offers a wide variety of merchandise.[4]

HEALTH TOOLS AND TRACKERS

Knowing what you eat and how much you work out can help you reach your goals. But keeping track of all you do can be time-consuming. To make it easy, the portal has trackers that let you record how much sleep you get, your stress levels, your blood pressure readings and your cholesterol levels.

The portal also offers a symptom checker. When you don't feel well, this tool can help you decide if you should see a doctor.

SELF-MANAGEMENT PROGRAMS

These programs consist of:

1. Interactive programs with learning activities and content that focus on behavioral changes to reinforce healthier habits.
2. Educational programs that inform about symptoms, treatment options and lifestyle changes.

These two learning methods allow you to study on your own time and may help you get to the next level of wellness. Topics include nutrition, weight management, physical activity, stress management, tobacco cessation and more.

FITNESS TRACKING

Earn Blue Points for tracking your fitness activity using popular fitness devices and mobile apps.

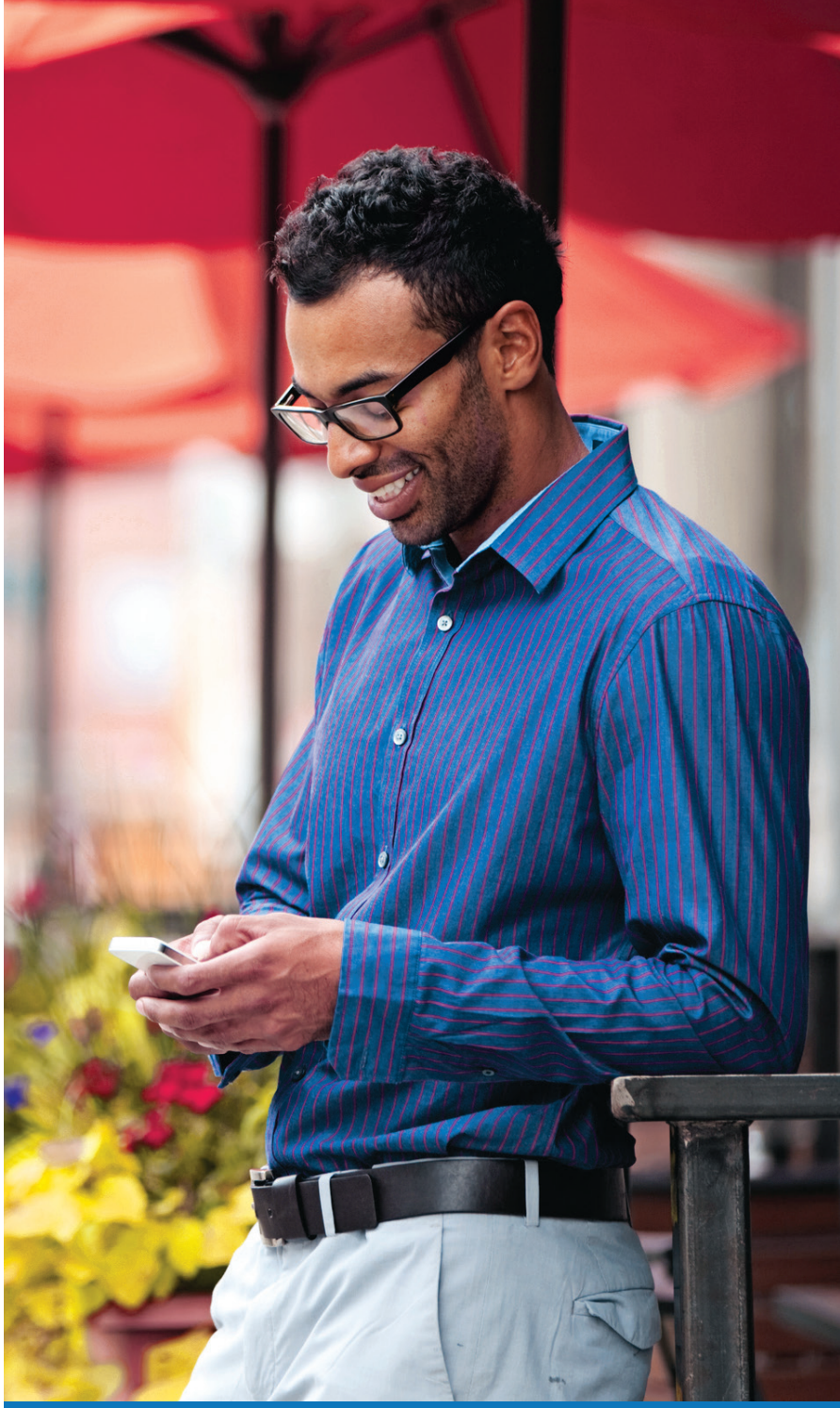
1 Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.

2 Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well onTarget Member Wellness Portal for more information.

3 This does not apply to points you earn for completing Fitness Program activities.

4 Member agrees to comply with all applicable federal, state and local laws, including making all disclosures and paying all taxes with respect to their receipt of any reward.

The Fitness Program is provided by Tivity Health®, an independent contractor that administers the Prime Network of fitness centers. The Prime Network is made up of independently owned and operated fitness centers.



Take Wellness on the Go

Check out the Well onTarget AlwaysOn Wellness mobile app, available for iPhone® and Android™ smartphones. It can help you work on your wellness goals — anytime and anywhere.

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Powered by MDLIVE®

BlueCross BlueShield of Texas

Texas Association of Counties Health and Employee Benefits Pool

Care When and Where You Need It Just Got Easier

Virtual Visits

Convenient health care at your fingertips

Powered by MDLIVE®

$10 Medical Copay and $35 Behavioral Health Copay*

Getting sick is never convenient, and finding time to get to the doctor can be hard. Blue Cross and Blue Shield of Texas (BCBSTX) provides you and your covered dependents access to care for non-emergency medical issues and behavioral health needs through MDLIVE.

Whether you're at home or traveling, access to an independently contracted board-certified doctor is available 24 hours a day, seven days a week. You can speak to a doctor immediately or schedule an appointment based on your availability. Virtual visits can also be a better alternative than going to the emergency room or urgent care center.

MDLIVE doctors or therapists can help treat the following conditions and more:

General Health
- Allergies
- Asthma
- Nausea
- Sinus infections

Pediatric Care
- Cold
- Flu
- Ear problems
- Pinkeye

Behavioral Health
- Anxiety/depression
- Child behavior/learning issues
- Marriage problems

* for HSA plans,$0 after plan year deductible has been satisfied

747798.0618

Connect
Computer, smartphone, tablet or telephone

Interact
Real-time consultation with a board-certified doctor or therapist

Diagnose
Prescriptions sent electronically to a pharmacy of your choice (when appropriate)

Website:
Visit the website
MDLIVE.com/BCBSTX

- Choose a doctor
- Video chat with the doctor
- You can also access through Blue Access for Members℠

Mobile app:
- Download the MDLIVE app from the Apple App Store℠ or Google Play™ Store
- Open the app and choose an MDLIVE doctor
- Chat with the doctor from your mobile device

Telephone:
- Call MDLIVE **888-680-8646**
- Speak with a health service specialist
- Speak with a doctor

Get connected today!
To register, you'll need to provide your first and last name, date of birth and BCBSTX member ID number.

Internet/Wi-Fi connection is needed for computer access. Data charges may apply. Check your cellular data or internet service provider's plan for details. Non-emergency medical service in Idaho, Montana and New Mexico is limited to interactive audio/video (video only), along with the ability to prescribe. Non-emergency medical service in Arkansas is limited to interactive audio/video (video only) for initial consultation, along with the ability to prescribe. Behavioral health service is limited to interactive audio/video (video only), along with the ability to prescribe in all states. Service availability depends on location at the time of consultation.

Virtual visits, powered by MDLIVE, may not be available on all plans. Virtual visits are subject to the terms and conditions of your benefit plan, including benefits, limitations, and exclusions. MDLIVE operates subject to state regulations and may not be available in certain states. MDLIVE is not an insurance product or a prescription fulfillment warehouse. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA-controlled substances, non-therapeutic drugs and certain other drugs that may be harmful because of their potential for abuse. MDLIVE physicians reserve the right to deny care for potential misuse of services.

BlueCross BlueShield of Texas

24/7 Nurseline

Nurses available anytime you need them.

Health happens – good or bad, 24 hours a day, seven days a week. That is why we have registered nurses waiting to talk to you whenever you call our 24/7 Nurseline.

Our nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Dizziness or severe headaches
- Cuts or burns
- Back pain
- High fever
- Sore throat
- Diabetes
- A baby's nonstop crying
- And much more

Plus when you call, you can access an audio library of more than 1,000 health topics – from allergies to surgeries – with more than 500 topics available in Spanish.

So, put the 24/7 Nurseline phone number in your contacts today, because health happens 24/7.

Call the 24/7 Nurseline number at **800-581-0393**.
Hours of Operation: Anytime

For medical emergencies, call 911. This program is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

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Deciding Where to Go? Virtual Visit, Doctor's Office, Retail Clinic, Urgent Care or ER.

	Virtual Visits powered by MDLIVE	Doctor's Office	Retail Health Clinic	Urgent Care Center	Hospital ER	Freestanding ER
						
Who usually provides care	**Primary Care Pediatrics, Family and Emergency Medicine Doctors**	**Primary Care Doctor**	**Physician Assistant or Nurse Practitioner**	**Internal Medicine, Family Practice and Pediatric**	**ER Doctors, Internal Medicine, Specialists**	**ER Doctors**
Sprains, strains		■	■	■	• Any life-threatening or disabling conditions • Sudden or unexplained loss of consciousness • Major injuries • Chest pain; numbness in the face, arm or leg; difficulty speaking • Severe shortness of breath • High fever with stiff neck, mental confusion or difficulty breathing • Coughing up or vomiting blood • Cut or wound that won't stop bleeding • Possible broken bones	• Most major injuries except for trauma[1] • May also provide imaging and lab services but do not offer trauma or cardiac services requiring catheterization[1] • Do not always accept ambulances
Animal bites		■	■	■		
X-rays				■		
Stitches				■		
Mild asthma	■	■	■	■		
Minor headaches	■	■	■	■		
Back pain		■	■	■		
Nausea, vomiting, diarrhea	■	■	■	■		
Minor allergic reactions	■	■	■	■		
Coughs, sore throat	■	■	■	■		
Bumps, cuts, scrapes	■	■	■	■		
Rashes, minor burns	■	■	■	■		
Minor fevers, colds	■	■	■	■		
Ear or sinus pain	■	■	■	■		
Burning with urination	■	■	■	■		
Eye swelling, irritation, redness or pain	■	■	■	■		
Vaccinations		■	■	■		

24/7 Nurseline[2]

The 24/7 Nurseline can help you identify some options when you or a family member have a health problem or concern. Nurses are available at **800-581-0393**, 24 hours a day, seven days a week, to answer your health questions.

Urgent Care Center or Freestanding ER

Knowing the Difference Can Save You Money

Urgent care centers and freestanding ERs can be hard to tell apart. Freestanding ERs often look a lot like urgent care centers, but costs may be higher. A visit to a freestanding ER often results in medical bills that may be 10 times the rate charged by urgent care centers for the same services.[3] Here are some ways to know if you are at a freestanding ER.

Freestanding ERs:

- Look like urgent care centers, but have the word "Emergency" in their name or on the building.
- Are open 24 hours a day, seven days a week.
- Are not attached to and may not be affiliated with a hospital.
- Are subject to the same ER member share which may include a copay, coinsurance and applicable deductible.

Find urgent care centers[4] near you by texting[5] **URGENTTX** to **33633**.

[1] "Freestanding ED 101: What you need to know" July 2016, The Advisory Board Company.

[2] 24/7 Nurseline is not a substitute for a doctor's care. Talk to your doctor about any health questions or concerns.

[3] Freestanding ERs: The Need for Greater Transparency and More Consumer Protections. (2016). The Texas Association of Health Plans.

[4] The closest urgent care center may not be in your network. Be sure to check Provider Finder® to make sure the center you go to is in-network.

[5] Message and data rates may apply. Read terms, conditions and privacy policy at bcbstx.com/mobile/text-messaging.

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BlueCross BlueShield of Texas

Behavioral Health

Feeling Worried? Sad? Out of Control? With help, you can start to feel better.

Most people have times when they don't feel their best. But when negative feelings get in the way of normal activities or last a long time, you may need extra support.

The good news is there are many treatments and support systems included with your health benefits.[1] With the right help, you can learn to help control your symptoms and live a full life.

You and your covered family members can get the support you may need for issues such as:

- Substance use
- Anxiety and panic attacks
- Attention deficit
- Autism
- Bipolar
- Depression
- Eating disorders
- Schizophrenia

Behavioral health professionals from Blue Cross and Blue Shield of Texas are experts in mental health. They can help you learn where and how to get help. Call the Customer Service or behavioral health number on the back of your member ID card to get started.

Start your path to a healthier mind and a more balanced life. Take the first step today.

To find a behavioral health provider in your area:

Go to **https://mybenefits.county.org.** Click on **Benefits**, then select **Links & Contacts** and **Go to Blue Cross Blue Shield Member Site**. Use the information on your member ID card to complete the process. Then, click **Find a Doctor or Hospital**.

Or call the Customer Service number on the back of your member ID card if you need help finding the right provider or have questions about your benefits.

1. The Behavioral Health program is available only to those members whose health plans include behavioral health benefits through Blue Cross and Blue Shield of Texas. Check your benefit booklet, ask your group administrator or call the Customer Service number on the back of your member ID card to verify that you have these services.

Member communications and information from the program are not meant to replace the advice of health care professionals. Members are encouraged to seek the advice of their doctors or behavioral health specialist to discuss their health care needs. Decisions regarding course and place of treatment remain with the member and his or her health care providers.

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BlueCross BlueShield of Texas

Special Beginnings®

Give your baby a healthy start.

It is never too early to start taking care of your baby. That's why you should join the Special Beginnings program as soon as you know you are pregnant.

The Special Beginnings maternity program supports you from early pregnancy until six weeks after delivery. An experienced Blue Cross and Blue Shield of Texas staff member will contact you and:

- Ask you questions to determine what support you will need
- Send you information, including a book about having a healthy pregnancy and baby
- Answer any questions you have and help you plan your care with your doctor
- Assist you with managing high-risk conditions such as gestational diabetes and preeclampsia

Visit the Special Beginnings website to view a video library and week-by-week pregnancy information. To access the site, log into Blue Access for Members℠ (BAM℠) by visiting **bcbstx.com** and click on the "My Health" tab.

Take good care of yourself and your baby – join Special Beginnings today!

It's free, easy and confidential.

Call 888-421-7781, 8 a.m. – 6:30 p.m., CT, to enroll or ask questions about the program.

Special Beginnings is not a substitute for professional medical guidance. Regular visits are important for your care. With your consent, the information we receive from you is shared with your physician to better coordinate your care. Be sure to discuss any health concerns with your physician.

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AIRROSTI

Texas Association of Counties

Healthy County Together. Better. Stronger.
Texas Association of Counties Health and Employee Benefits Pool

FIX PAIN FAST!

HEALTH PLAN BENEFIT

For all employees and dependents on the health plan offered by

Texas Association of Counties

Airrosti visits are a $25.00 copay with the Buy-up Plan.
Airrosti visits are subject to annual deductible and coinsurance with the Base and HDHP Plans.

Airrosti providers are experts at diagnosing and rapidly resolving the source of your injury.

Each patient receives one full hour of assessment, diagnosis, treatment, and education designed to eliminate the pain associated with many common conditions, allowing you to quickly and safely return to activity - usually within 3 visits (based on patient-reported outcomes).

Schedule Your Appointment Today!

3.2 visits average to complete injury resolution*

*Based on patient reported outcomes

80% REDUCTION IN SURGICAL OCCURRENCE RATE

43% REDUCTION IN TOTAL COST OF CARE

(800) 404-6050 | AIRROSTI.COM

Healthy County Together. Better. Stronger.
Texas Association of Counties Health and Employee Benefits Pool

CLINICAL EXPERTISE. *CONVENIENT ACCESS.*

Airrosti has a proven track record of diagnosing and resolving musculoskeletal conditions, including neck and back pain, tendonitis, muscle pulls, and more. Now, Airrosti's provider expertise is available through a convenient, affordable, and effective digital solution.

IMPORTANT NEW HEALTH PLAN BENEFIT:

AIRROSTI'S UNPARALLELED MUSCULOSKELETAL EXPERTISE, DELIVERED VIRTUALLY.

Expert Diagnosis and Care

During the initial video consultation, a licensed Airrosti clinician will provide:

- Step-by-Step Orthopedic Evaluation
- Accurate Diagnosis
- Injury-Specific Education
- Individualized Recovery Plan
- Referral Coordination As Needed

Personalized Program

Your Airrosti Care Team will prescribe a customized recovery plan delivered through the user-friendly app, which includes:

- Mobility and Stability Exercises
- Self-Myofascial Release
- Remote Recovery Kit
- Unlimited Provider Interaction

Progress and Support

Recovery is tracked in real time, and treatment is modified as needed to ensure continued improvement.

In-app messaging gives you unlimited access to your Care Team — anywhere, anytime.

AIRROSTI REMOTE RECOVERY IS NOW A COVERED BENEFIT.

Visit Airrosti.com/RemoteRecovery or scan the QR code at right to learn more and to begin your remote recovery plan. If you have any questions about this important benefit designed to get you back to living life pain free, call (855) 913-0845.

SCAN ME

AIRROSTI.COM/REMOTERECOVERY **(855) 913-0845**

Healthy County Together. Better. Stronger.

Texas Association of Counties Health and Employee Benefits Pool

Livongo®

The Simpler Way To A Healthier You

An advanced blood glucose meter, plus the support you need, 100% paid for by the Texas Association of Counties Health and Employee Benefits Pool.

Join Livongo and you'll get:

- Advanced devices to monitor your blood sugar
- Automatic uploads mean no more logbooks
- Real-time support from coaches when you need it
- Summary reports you can send your doctor
- Personalized tips and articles picked just for you
- Optional family alerts to keep everyone in the loop

Unlimited strips. Unlimited inspiration. It's all at no cost to you.

Join today at **get.livongo.com/HEALTHYCOUNTY/register** or call **(800) 945-4355**

Use registration code: HEALTHYCOUNTY

These programs are provided to you and your family members with diabetes and coverage through Texas Association of Counties Health and Employee Benefits Pool (TAC HEBP) in partnership with Blue Cross and Blue Shield of Texas (BCBSTX).

Members must have primary insurance coverage through the Blue Cross and Blue Shield of Texas (BCBSTX) plan offering the Livongo program. For Administrative Services Only (ASO) and Preferred Provider Organizations (PPO) only. Not available for Fully Insured (FI) or Health Maintenance Organizations (HMO).

Programs include trends and support on your secure Livongo account and mobile app but does not include a phone or tablet. You must have an iPhone or Android smartphone and install the Livongo app to participate in the Livongo for Hypertension Program.

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BlueCross BlueShield of Texas

Blue365®
Because health is a big deal℠

Blue365®

A Discount Program for You

Blue365 is just one more advantage you have by being a Blue Cross and Blue Shield of Texas (BCBSTX) member. With this program, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or preauthorizations.

Once you sign up for Blue365 at **blue365deals.com/bcbstx**, weekly "Featured Deals" will be emailed to you. These deals offer special savings for a short period of time.

Below are some of the ongoing deals offered through Blue365.

EyeMed | Davis Vision
You can save on eye exams, eyeglasses, contact lenses and accessories. You have access to national and regional retail stores and local eye doctors. You may also get possible savings on laser vision correction.

Dental Solutions℠
You could get dental savings with Dental Solutions. You may receive a dental discount card that provides access to discounts of up to 50% at more than 70,000 dentists and more than 254,000 locations.*

TruHearing® | Beltone™ | American Hearing Benefits
You could get savings on hearing tests, evaluations and hearing aids. Discounts may also be available for your immediate family members.

Jenny Craig® | Sun Basket | Nutrisystem®
Help reach your weight loss goals with savings from leading programs. You may save on healthy meals, membership fees (where applicable), nutritional products and services.

See all the Blue365 deals and learn more at **blue365deals.com/bcbstx**.

BlueCross BlueShield of Texas

Blue365®
Because health is a big deal℠

Fitbit®

You can customize your workout routine with Fitbit's family of trackers and smartwatches that can be employed seamlessly with your lifestyle, your budget and your goals. You'll get a 20% discount on Fitbit devices plus free shipping.

Reebok | SKECHERS®

Reebok, a trusted brand for more than 100 years, makes top athletic equipment for all people, from professional athletes to kids playing soccer. Get 20% off select models. SKECHERS, an award-winning leader in the footwear industry, offers exclusive pricing on select men's and women's styles. You can get 30% off plus free shipping for your online orders.

InVite® Health

InVite Health offers quality vitamins and supplements, educational resources and a team of healthcare experts for guidance to select the correct product at the best value. Get 50% off the retail price of non-genetically modified microorganism (non-GMO) vitamins and supplements and a free Midnight Bright Black Coconut Charcoal Tooth Polish with a $25 purchase.

Livekick

Livekick is the future of private fitness. Choose from training or yoga over live video with a private coach. Get fit and feel healthier with action-packed 30-minute sessions that you can do from home, your gym or your hotel while traveling. Get a free two-week trial and 20% off a monthly plan on any Live Online Personal Training.

eMindful

Get a 25% discount on any of eMindful's live streaming or recorded premium courses. Apply mindfulness to your life including stress reduction, mindful eating, chronic pain management, yoga, Qigong movements and more.

For more great deals, or to learn more about Blue365, visit **blue365deals.com/bcbstx**.

The relationship between these vendors and Blue Cross and Blue Shield of Texas (BCBSTX) is that of independent contractors. BCBSTX makes no endorsement, representations or warranties regarding any products or services offered by the above-mentioned vendors.

* Dental Solutions requires a $9.95 signup and $6 monthly fee.

Blue365 is a discount program only for BCBSTX members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. You should check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are given only through vendors that take part in this program and may be subject to change. BCBSTX does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSTX reserves the right to stop or change this program at any time without notice.

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BlueCross BlueShield of Texas

Blue365
Because health is a big deal℠

Blue365®
EyeMed Vision Discount Program

Blue Cross and Blue Shield of Texas (BCBSTX) is pleased to offer you a vision discount program through EyeMed Vision Care.

What?
The EyeMed Vision Discount through Blue365 offers savings on eyeglasses, contact lenses, eye exams, accessories and laser vision correction. See the back page for a full list of discounts.

Who?
The EyeMed network consists of major national and regional retail locations, such as LENSCRAFTERS®, PEARLE VISION®, Target Optical®, Sears Optical® and JCPenney Optical, as well as independent ophthalmologists and optometrists. Additionally, you may go online to in-network providers at **contactsdirect.com**.

Where?
Visit **eyemedexchange.com/blue365**, click Find a Provider and begin your search. Be sure the Advantage network is selected.

For more information about Blue365, log in to Blue Access for Members℠ (BAM℠) at **https://mybenefits.county.org**. Click on Benefits, then select Links & Contacts and Go to Blue Cross Blue Shield Member Site. Use the information on your member ID card to complete the process.

Referral?
You don't need a referral. Simply visit any EyeMed provider and show your BCBSTX medical ID card.

Program Features
- Discounts on vision care services and materials
- No limit to the number of times the member can receive discounts on purchases
- Access to large provider network
- Convenient evening and weekend hours

Note: This is not insurance. When contacting EyeMed or any retailer or provider in the EyeMed Advantage network, be sure to refer to the discount program.

See all the Blue365 deals and learn more at **blue365deals.com/BCBSTX**.

EyeMed Vision Discounts

For more information, visit eyemedexchange.com/blue365 or call EyeMed's automated help line at 866-273-0813.

Vision Care Services	Cost
Exam with dilation as necessary:	$50 routine exam $10 off contact lens fit and follow-up
Complete Pair of Glasses Purchase: frame, standard plastic lenses, and lens options must be purchased in the same transaction to receive full discount	
Frames*	
Any frame available at provider location	35% off retail price
Standard Plastic Lenses*	
Single-vision	$50
Bifocal	$70
Trifocal	$105
Lenticular	$105
Standard Progressive	$135
Premium Progressive	30% off retail price
Lens Options*	
UV Coating	$12
Tint (Solid and Gradient)	$12
Standard Scratch-resistance	$12
Standard Polycarbonate	$35
Standard Anti-reflective	$40
Other Add-ons and Services	30% off retail price
* Items purchased separately will be discounted 20% off of the retail price.	
Contact Lens Materials (applied to materials only)	
Conventional	15% off retail price
Laser Vision Correction	
Lasik or PRK	15% off retail price or 5% off promotional price
Frequency	
Examination	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact Lenses	Unlimited

Discounts are only available through participating vendors.

The relationships between Blue Cross and Blue Shield of Texas (BCBSTX) and EyeMed are that of independent contractors.

Blue365 is a discount program available to BCBSTX members. This is NOT insurance. Some of the services offered through Blue365 may be covered under your health plan. Please refer to your benefit booklet or call the Customer Service number on the back of your ID card for specific benefit information under your health plan. Use of Blue365 does not affect your premium, nor do costs of Blue365's services or products count toward any maximums and/or plan deductibles.

BCBSTX does not guarantee or make any claims or recommendations regarding the services or products offered under Blue365. You may want to consult with your physician prior to use of these services and products. Services and products are subject to availability by location. BCBSTX reserves the right to discontinue or change this discount program at any time without notice.

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BlueCross BlueShield of Texas

Blue365® Davis Vision℠ Discount Program

Blue Cross and Blue Shield of Texas (BCBSTX) is pleased to offer BCBSTX members a vision discount program through Davis Vision, a national provider of vision care programs.

What is the Davis Vision discount program?

This is a program that may offer savings on eyeglasses, contact lenses, eye exams, accessories and laser vision correction. See the back page for a full list of discounts.

How do I locate a Davis Vision provider?

The Davis Vision network consists of major national and regional retail locations, such as Visionworks®, Walmart® and Costco®, as well as independent ophthalmologists and optometrists.

For a list of Davis Vision providers near you, go to davisvision.com, click *Member* and enter Client Code 4513 in the *Open Enrollment* section, or call Davis Vision at 888-897-9350. For more information about Blue365, log in to Blue Access for Members℠ at https://mybenefits.county.org. Click on *Benefits*, then select *Links & Contacts* and *Go to Blue Cross Blue Shield Member Site*. Use the information on your member ID card to complete the process. Click the *My Coverage* tab at the top, and then click the *Discount* link on the left.

Are there any exclusions?

The following items are ***not*** covered by this vision discount program:

- Medical treatment of eye disease or injury
- Vision therapy
- Special lens designs or coatings, other than those listed on the other side of this flier
- Services performed by a provider who is not in the Davis Vision network
- Replacement of lost eyewear
- Services not performed by licensed personnel

https://mybenefits.county.org

What discounts are available in the vision program?[1]

If your plan offers vision benefits, see your BCBSTX network provider for your initial eye exam. You may be able to receive the discounts listed below on vision hardware materials when using a Davis Vision provider and presenting your BCBSTX card.

In addition to the discounted rates below, there are other value-added features that may be available to you, including discounts on disposable contact lenses through Davis Vision's mail-order contact lens replacement program. For more information, contact Davis Vision at 888-897-9350 or visit davisvisioncontacts.com.

	You May Pay:
Examinations	
Comprehensive examination	15% off or $5 off retail cost
Contact lens examination	15% off or $10 off retail cost
Frames[2]	
Priced up to $70 retail	$40
Priced over $70 retail	$40 plus 10% off the amount over $70
Spectacle Lenses (Uncoated Plastic)[2]	
Single vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
Contact Lenses	
Conventional[3]	20% off
Disposable/planned replacement[3]	10% off
Spectacle Lens Options (Add to Lens Prices)[2]	
Standard progressive[4]	$60
Premium progressive[4]	$110
Glass lenses	$18
Polycarbonate lenses	$30
Blended invisible bifocals	$20
Intermediate vision lenses	$30
Photogrey Extra® lenses	$35
Scratch-resistant coating	$15
Anti-reflective coating	$45
Ultraviolet coating	$15
Solid tint	$10
Gradient tint	$12
Hi-index lenses	$55
Photochromic lenses (e.g., Transitions®)	$65
Polarized lenses	$75

For more information:

Call Davis Vision at **888-897-9350** (Monday through Friday, 7 a.m. to 10 p.m., Saturday, 8 a.m. to 3 p.m., Sunday, 11 a.m. to 3 p.m., Central Time).

Visit **davisvision.com**, click *Member* and enter Client Code 4513 in the *Open Enrollment* section.

1 These discounted fees apply at most provider locations. However, fees may vary. For example, at Walmart or Sam's Club®, members will receive comparable values on spectacle lens and contact lens purchases with the applicable standard retail cost. Members buying frames at either provider will receive a flat 10 percent discount on the price, rather than the discounts shown. Confirm discounts with your selected provider.

2 Special lens designs, materials, powers and frames may require additional cost.

3 Discount will be applied to the provider's usual and customary price for services.

4 Pricing at some retail locations may vary.

The relationships between Blue Cross and Blue Shield of Texas (BCBSTX) and Davis Vision, Inc., is that of independent contractors.

Blue365 is a discount program available to BCBSTX members. This is *not* insurance. Some of the services offered through Blue365 may be covered under your health plan. Please refer to your benefit booklet or call the Customer Service number on the back of your ID card for specific benefit information under your health plan. Use of Blue365 does not affect your premium, nor do costs of Blue365's services or products count toward any maximums and/or plan deductibles. Discounts are only available through participating vendors.

BCBSTX does not guarantee or make any claims or recommendations regarding the services or products offered under Blue365. You may want to consult with your physician prior to use of these services and products. Services and products are subject to availability by location. BCBSTX reserves the right to discontinue or change this discount program at any time without notice.

VI.
Important Notices

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Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

You may be eligible for assistance paying your employer health plan premiums. In Texas, contact information regarding eligibility is listed below.

Website: http://gethipptexas.com/

Phone: 1-800-440-0493

For information about premium assistance in other states, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Women's Health and Cancer Rights Act of 1998 Notification

In 1998, the U.S. Congress passed the Women's Health and Cancer Rights Act of 1998 that provides coverage for reconstructive surgery and related services following a mastectomy in conjunction with a diagnosis of breast cancer.

In the case of a covered person receiving benefits under their plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- Coverage will be provided for the reconstructive surgery of the breast on which a mastectomy has been performed.
- Coverage will be provided for surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Coverage will be provided for prostheses and physical complications through all stages of a mastectomy, including swelling associated with the removal of lymph nodes.

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally, may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to 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 if applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA prohibits employers and other entities covered by GINA from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which an individual may be at risk

TEXAS ASSOCIATION of COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL

Notice to Enrollees in the TAC HEBP Group Health Plan

Group health plans sponsored by a local government entity such as the Texas Association of Counties Health and Employee Benefits Pool (TAC HEBP) must generally comply with Federal law requirements in Title XXVII of the Public Health Services Act. However, TAC HEBP is permitted to elect to be exempt from the requirement listed below because TAC HEBP's plan is "self-funded", rather than provided through a health insurance policy. TAC HEBP has elected to be exempt from the following requirement:

- Protections against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the plan.

The exemption from this Federal requirement will be in effect for the plan year beginning October 1, 2020 and ending September 30, 2021. The election may be renewed for subsequent years.

BlueCross BlueShield of Texas

Important Notices

Initial Notice About Special Enrollment Rights in Your Group Health Plan

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about very important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" without being considered a late enrollee if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Section I of this notice may not apply to certain self-insured, non-federal governmental plans. Contact your employer or plan administrator for more information.

A. SPECIAL ENROLLMENT PROVISIONS

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if you move out of an HMO service area, or the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or move out of the prior plan's HMO service area, or after the employer stops contributing toward the other coverage).

Loss of Coverage For Medicaid or a State Children's Health Insurance Program
If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption
If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for State Premium Assistance for Enrollees of Medicaid or a State Children's Health Insurance Program
If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

II. Additional Notices

Other federal laws require we notify you of additional provisions of your plan.

NOTICES OF RIGHT TO DESIGNATE A PRIMARY CARE PROVIDER (FOR NON-GRANDFATHERED HEALTH PLANS ONLY)

For plans that require or allow for the designation of primary care providers by participants or beneficiaries: If the plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

For plans that require or allow for the designation of a primary care provider for a child: For children, you may designate a pediatrician as the primary care provider.

For plans that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider: You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in pediatrics, obstetrics or gynecology, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

TEXAS ASSOCIATION *of* COUNTIES
HEALTH AND EMPLOYEE BENEFITS POOL

NOTICE OF PRIVACY PRACTICES

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.

I. USE AND DISCLOSURE OF HEALTH INFORMATION

The Texas Association of Counties Health and Employee Benefits Pool ("Pool") has created a health plan that provides health coverages for employees (and their dependents) of the counties and county-related entities that are members of the Pool ("the Plan"). The Plan is subject to the requirements of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Privacy Rule published by the United States Department of Health and Human Services at 45 CFR §§ 160 -164 ("Privacy Rule"). HIPAA and the Rule regulate the Plan's use of your protected health information.

The Plan may use your protected health information for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed without getting an authorization from you or giving you a chance to agree or object to the disclosure:

A. To Make or Obtain Payment.
The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

B. To Conduct Health Care Operations.
The Plan may use or disclose health information for its own health care operations, to facilitate the administration of the Plan, and as necessary to provide coverage and services to all of the Plan's participants. If the Plan needs to use your information, but does not need to disclose it to third parties, it will be used but will not be disclosed. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or similar activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits. However, while we may use and disclose your health information for underwriting purposes, we are prohibited from using or disclosing genetic information of an individual for such purposes.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development, including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Plan, including customer service and resolution of internal grievances.

For example, the Plan may use your health information to conduct case management reviews, to review and assess the quality of the various components of the Plan and the utilized health care providers, or to engage in customer service and grievance resolution activities.

C. For Treatment Alternatives.
The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

D. For Distribution of Health-Related Benefits and Services.
The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

E. For Disclosure to the Plan Sponsor.
The Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the plan. The Plan also may disclose to the plan sponsor information on whether you are participating in the health plan.

In addition, the Plan may disclose your protected health information (PHI) to the plan sponsor as necessary for the plan sponsor to perform administration functions on behalf of the Plan. The Plan will not provide your name in connection with your health information and will otherwise de-identify the information to the extent it is practical to do so. PHI will be disclosed to the plan sponsor only upon receipt of a certification by the plan sponsor that the plan sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the plan documents or as required by law;
- Ensure that any agents to whom it provides PHI received from HEBP agree to the same restrictions that apply to the plan sponsor with respect to such information;
- Not use or disclose the information for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;
- Report to HEBP any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make available PHI for amendment and incorporate any amendments to PHI agreed to or required by HEBP;
- Make PHI available to an individual who has a right to access it pursuant to the Privacy Rule;
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule;
- Make its internal practices, books, and records relating to the use and disclosure of PHI received form HEBP available to the Secretary for purposes of determining compliance by HEBP with the Privacy Rule; and
- If feasible, return or destroy all PHI received from HEBP that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made.

Any PHI disclosed by the Plan will be disclosed to the Pool Coordinator designated by the Plan Sponsor. The Plan Sponsor will restrict access to and use of PHI to those individuals who need it to perform plan administration functions or to obtain bids for health coverage. The plan sponsor will provide an effective mechanism for resolving any issues if such persons use or disclose your PHI inappropriately.

F. When Legally Required.
The Plan will disclose your health information when it is required to do so by any federal, state or local law.

G.To Conduct Health Oversight Activities.
The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

H.In Connection With Judicial and Administrative Proceedings.
The Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

I. For Law Enforcement Purposes.
As permitted or required by state law, the Plan may disclose your protected health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

J. In the Event of a Serious Threat to Health or Safety.
The Plan may, consistent with applicable law and ethical standards of conduct, disclose your protected health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

K.For Specialized Government Functions.
We may be required to disclose your information to federal authorities. Federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

L. For Worker's Compensation.
The Plan may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.

M. Public Health Activities.
The Plan may disclose your protected health information to a public health authority authorized by law to collect such information to prevent or control disease, injury, or disability, and to report such information as birth or death, the conduct of public health surveillance and public health investigations. The Plan also may disclose your information to an appropriate government authority authorized to receive reports about child abuse. The Plan also may disclose your information to a person responsible for activities related to the quality, safety and effectiveness of products regulated by the federal Food and Drug Administration. The Plan may disclose your protected health information to a government authority if there is a reasonable belief that you are a victim of abuse, neglect, or domestic violence.

II. AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Plan will not disclose your health information unless you give us your written authorization. Specifically, we must have your written authorization to use or disclose psychotherapy notes except as permitted or required by law and personal information for marketing purposes, in most instances. In addition, we do not sell your personal information. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time, unless the Plan has taken an action based on your authorization.

III. YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Plan maintains:

A. Right to Request Restrictions.
You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. The Plan is not required to agree to your request, but will certainly consider it. We must, however, agree to any request you may make to restrict disclosure of your personal information to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the information pertains solely to a health care item or service for which you or someone acting on your behalf paid the provider in full. If you wish to make a request for restrictions, please contact TAC HBS Operations Manager at 800-456-5974.

B. Right to Receive Confidential Communications.
You have the right to request that the Plan communicate with you in a certain way if you feel it is necessary to protect your interests. For example, you may ask that the Plan only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to TAC HBS Operations Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. The Plan will honor your reasonable requests for confidential communications.

C. Right to Inspect and Copy Your Health Information.
You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to TAC HBS Operations Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. If you request a copy of your health information, the Plan may charge a reasonable fee for labor for copying, the costs of supplies for creating an electronic copy on portable media, the cost of preparing an explanation or summary of the information if you agree, and postage, if applicable, associated with your request.

D. Right to Amend Your Health Information.
If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend any records in its possession. A request for an amendment of records must be made in writing, must express a reason the records should be amended, and must be sent to TAC HBS Operations Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the information requested is not part of a designated record set, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy (including psychotherapy notes, and information compiled for or in anticipation of a civil, criminal or administrative proceeding), or if the Plan determines the records containing your health information are accurate and complete.

E. Right to an Accounting.
The Privacy Rule requires the Plan to keep a record of certain disclosures of health information, such as

disclosures for public purposes authorized by law or disclosures that are not in accordance with the Plan's privacy policies and applicable law. You have the right to request a copy of this record. The request must be made in writing to TAC HBS Operations Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

F. Right to a Paper Copy of this Notice.
You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact TAC HBS Operations Manager, P.O. Box 2131, Austin, Texas 78768, Fax 512-481-8481. You also may view a copy of the current version of the Plan's Privacy Notice at the Web site, http://www.County.Org.

IV. DUTIES OF TAC HEBP HEALTH PLAN

The Plan is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Plan is also required by law to notify any affected individuals following a breach of their unsecured protected health information. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. The Plan will also post the revised Notice on its website by the effective date of the Notice. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to TAC HEBP Privacy Official, Rob Ressmann, P.O. Box 2131, Austin, Texas 78768, Fax: 512-478-0519. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON
The Plan has designated Rob Ressmann, Privacy Official as its contact person for all issues regarding patient privacy and your privacy rights. You may contact him at P.O. Box 2131, Austin, Texas 78768, 512-478-8753.

EFFECTIVE DATE
This Notice is effective Nov 8, 2013.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, please contact Rob Ressmann, TAC HEBP Privacy Official, P.O. Box 2131, Austin, Texas 78768, 512-478-8753.

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