



## OUTLINE OF COVERAGE Individual Major Medical Coverage

**Policy and Medical Claims Administered By:** Blue Cross and Blue Shield of Texas\*  
**Address:** P. O. Box 6089, Abilene, TX 79608-6089  
**Toll Free Number:** 1-888-398-3927  
(Administrator)

**Pharmacy Program Administered By:** Medco Health Solutions, Inc.  
**Address:** 100 Parsons Pond Drive  
Franklin Lakes, NJ 07147  
**Toll Free Number:** 1-800-290-1708  
(Pharmacy Manager)

The Texas Health Insurance Risk Pool (the Pool) was created by the Texas legislature to offer health insurance to residents of the state through participation of health insurance companies. This program is designed to provide health insurance to those Texas residents who are unable to obtain adequate health coverage due to their medical condition or who are considered Federally Eligible Individuals as defined by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

- I. READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of the important features of Your Policy. Please see the Definitions in Section IX for important terms used in this outline. This is not the insurance policy and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and the Pool. It is, therefore, important that You **READ YOUR POLICY CAREFULLY! Your application and Your acceptance of the Policy, if issued, constitute Your agreement to the terms and limitations of the Policy.**
- II.** This Policy is designed to provide eligible individuals with coverage for major hospital, medical, and surgical expenses, incurred as the result of a covered injury or sickness. Only eligible individuals and their Dependents and Family Members are eligible for coverage by the Pool.
- A. Eligibility for Coverage**
1. You are eligible for coverage by the Pool if You are and remain a legal resident of Texas and You provide evidence that You are a Federally Eligible Individual who has not experienced a Significant Break in Coverage.
  2. You are eligible for coverage by the Pool if You are under age 65, You are and remain a legal resident of Texas, and You provide evidence that You maintained Health Benefit Plan coverage under another state's qualified Health Insurance Portability and Accountability Act health program that was terminated because You no longer resided in that state, provided You submit an application for Pool coverage no later than the 63rd day after such other coverage was terminated.
  3. You are eligible for coverage by the Pool if You are under age 65 (or over the age of 65 and not enrolled in Medicare Part B), and remain a legal resident of Texas and You provide evidence that You are certified as eligible under Trade Adjustment Assistance or the Pension Benefit Guaranty Corporation (collectively, the HCTC Program).
  4. You are also an eligible individual if You are under age 65, have been for at least 30 days and remain a legal resident of Texas and a United States citizen or a permanent legal resident of the United States for at least three continuous years, and You provide evidence to the Pool's Administrator of one of the following:
    - a. A notice of rejection or refusal by an Insurance Company to issue substantially similar individual Health Benefit Plan coverage to You for health reasons;

- b. A certification from an agent or salaried representative of an Insurance Company, on the Pool's Application form, that states the agent or representative is unable to obtain substantially similar individual Health Benefit Plan coverage for You with any state-licensed Insurance Company, which the agent or representative represents, because You will be declined for coverage, as a result of Your medical condition, under the underwriting guidelines of the Insurance Company.
  - c. An offer by an Insurance Company to issue substantially similar individual Health Benefit Plan coverage to You only with conditional riders, which exclude coverage for medical conditions; or
  - d. You have been diagnosed with one of the following medical conditions, determined as a condition for automatic eligibility by the Pool Board of Directors:
    - Cancer
      - Malignant Tumor within 4 years (except skin cancer)
      - Metastatic
    - Cardiovascular
      - Artificial Heart Valve
      - Cardiomyopathy
      - Coronary Artery Disease
      - Polyarteritis Nodosa
      - Peripheral Vascular Disease, including Intermittent Claudication
    - Endocrine/Exocrine
      - Diabetes Mellitus
      - Cystic Fibrosis
      - Addison's Disease
    - Gastrointestinal
      - Intestinal
        - Crohn's Disease
        - Ulcerative Colitis
      - Liver
        - Cirrhosis (non-alcoholic)
        - Wilson's Disease
        - Hepatitis
    - Hematopoietic
      - Anemia
        - Sickle Cell
        - Splenic (True Banti's Syndrome)
      - Hemophilia
      - Leukemia
      - Thalassemia
    - Hodgkin's Disease
    - Immunological
      - Acquired Immune Deficiency Syndrome (AIDS) or HIV Positive
      - Lupus
      - Musculoskeletal
      - Dermatomyositis or Polymyositis
      - Muscular Atrophy or Dystrophy
      - Myotonia
      - Rheumatoid Arthritis
      - Still's Disease
      - Legge-Perthes Disease (Waldenstrom's Disease)
    - Neurological – Central Nervous System
      - Cerebral Palsy
      - Cerebral Vascular Accident (CVA)
      - Epilepsy
      - Huntington's Chorea
      - Hydrocephalus
      - Lead Poisoning with Cerebral Involvement
      - Lobotomy
      - Parkinson's Disease (if treatment within last 3 years)
      - Guillian-Barre Syndrome
    - Neurological – Peripheral Nervous System (including Spinal Cord)
      - Amyotrophic Lateral Sclerosis (ALS)
      - Friedrich's Ataxia
      - Myasthenia Gravis
      - Paraplegia or Quadriplegia
      - Sclerosis, Multiple, Disseminated or Postero-lateral
      - Syringomyelia
      - Tabes Dorsalis (Locomotor Ataxia)
    - Psychiatric
      - Psychotic Disorders
    - Pulmonary
      - Silicosis (Black Lung)
    - Renal
      - Polycystic Kidney
    - Other
      - Brain Tumor
      - Down's Syndrome
      - Scleroderma
      - Transplants
        - Heart
        - Kidney
        - Liver
        - Lung
5. Dependents: Your Dependents are also eligible for coverage by the Pool. If the eligible individual is a child, Family Members of the child who have been for at least 30 days and remain legal residents of Texas and United States citizens and who reside with the child are also eligible for coverage by the Pool.

## **B. Persons Not Eligible**

Even if You meet an eligibility requirement above, You are not eligible for coverage by the Pool if one or more of the following applies:

1. You have other Health Benefit Plan coverage in effect on the date Pool coverage would otherwise be effective (This does not apply to eligibility under the HCTC Program. In the case of coverage by Medicare, You are allowed to retain Medicare coverage if You otherwise qualify for the Pool. The Pool's coverage will be secondary to coverage provided by Medicare.).
2. You are eligible for or covered by Group Health Plan coverage, including a self-insured health benefit plan or continuation of coverage under state or federal law, unless you qualify under one of the following exceptions:
  - a. Your Group Health Plan coverage, continued under state or federal law, is maintained for the period of time necessary to satisfy any Preexisting Condition limitation period for Pool coverage or during any preexisting condition waiting period or other waiting period of the Group Health coverage (does not apply to eligibility under the HCTC Program); or
  - b. Your Group Health Plan, Church Plan or Governmental Plan coverage either excludes an individual or limits coverage for an individual by conditional riders; a pre-existing condition limitation of a benefit plan does not constitute an exclusion or a conditional rider of an individual or an individual's medical condition (does not apply to eligibility under the HCTC Program).
  - c. You are a part-time employee of an employer (You usually work less than 30 hours a week for the employer), the Group Health Plan offered by the employer is more limited or restricted than the Pool coverage, as determined by the Pool in its sole discretion, and the employer does not pay, directly or indirectly, any portion of the cost of Your coverage under the Group Health Plan (a copy of the coverage document for the employer's coverage and proof that the employer pays no portion of the cost, either directly or indirectly, will be required); or
  - d. You were eligible for continuation under federal law (Title X, Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA)), but You either did not elect continuation of coverage during the election period or Your elected continuation of coverage has lapsed or been cancelled without reinstatement, provided, however, that if You qualify under this section, You are subject to a Pool coverage exclusion of at least 180 days from the Pool coverage effective date for any Preexisting Condition, regardless of Your prior Creditable Coverage.

Note: If You or Your dependents were covered by a prior Group Health Plan, Church Plan or Governmental Plan, You and Your dependents may be eligible for state continuation or COBRA continuation of coverage. If You are eligible for state continuation of coverage, You are not eligible for Pool coverage until the scheduled termination date of such coverage. If You are eligible for and offered COBRA continuation, You may be eligible for Pool coverage pursuant to Section II B, subsection 2d. A dependent, covered under the terminating prior Group Health Plan, Church Plan or Governmental Plan is entitled to continuation, regardless of the continuation election of the employee.

3. You are covered by individual Health Benefit Plan coverage, unless You cancel or lapse such other coverage within 60 days after the effective date of Pool coverage. If such other individual Health Benefit Plan coverage limits coverage for an individual by excluding one or more medical conditions, such other coverage may be continued while the Pool coverage is in force. During any period other individual Health Benefit Plan coverage is in effect, after the effective date of Your Pool coverage, the Pool coverage will be secondary to such other coverage.
4. You have terminated coverage through the Pool within the twelve months preceding Your application for coverage by the Pool, unless You demonstrate a good faith reason for the termination (item 4 does not apply to persons eligible as Federally Defined Eligible Individuals.);
5. You are confined to a county jail or imprisoned in a state or federal prison.
6. You have premiums paid or reimbursed by or under any government sponsored program or any government agency or health care provider (does not apply to eligibility under the HCTC Program).
7. You had prior coverage by the Pool that was terminated for nonpayment of premiums within the twelve months preceding Your application for coverage by the Pool.
8. You had prior coverage by the Pool that was terminated for fraud.
9. You have received \$2,000,000 in benefits from the Pool under this Policy, including the benefits paid under any other Pool policies.

## **III. Preexisting Condition Limitation**

During the first 12 months following Your effective date of coverage, the Policy will not pay benefits for any charges or expenses for a Preexisting Condition. A Preexisting Condition is a disease or condition: for which the existence of symptoms would cause an ordinarily prudent person to seek diagnosis, care or treatment during the six month's before an Insured Person's effective date of coverage; or for which medical advice, care or treatment was recommended or received during the 6 months prior to an Insured Person's effective date of coverage. Preexisting Condition includes a preexisting pregnancy or a complication of a preexisting pregnancy, whether the complication occurs before or after the effective date of coverage. Preexisting Condition does not include genetic information, in the absence of a diagnosis of the condition related to the genetic information.

The Preexisting Condition limitation will not apply to an Insured Person who is a Federally Defined Eligible Individual, eligible pursuant to Section II A, subsection 1.

The Preexisting Condition limitation will not apply if You are eligible for Pool coverage under the HCTC Program and You were continuously covered for an aggregate period of 3 months of Creditable Coverage that was in effect up to a date not more than 63 days before Your effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy is made no later than 63 days following the termination of such Creditable Coverage.

Except for an Insured Person who is eligible under Section II B, subsection 2d (qualification under the COBRA exception), the Preexisting Condition limitation will not apply to an Insured Person who: was continuously covered for an aggregate period of 12 months by Creditable Coverage that was in effect up to a date not more than 63 days before the Insured Person's effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy for the Insured Person is made no later than 63 days following the termination of such Creditable Coverage; or has been continuously covered, since birth, adoption or Your suit for adoption of the Insured Person, by Creditable Coverage that was in effect up to a date not more than 63 days before the Insured Person's effective date under this Policy, excluding any waiting period, provided that application for coverage under this Policy for the Insured Person is made no later than 63 days following the termination of such Creditable Coverage. In determining whether the Preexisting Condition limitation applies to You, credit will be given for the time You were covered under any prior Creditable Coverage, including any waiting period for that coverage, that was in effect at any time during the 12 months before Your effective date under this Policy.

An Insured Person, who is eligible under Section II B, subsection 2d (qualification under the COBRA exception), will be subject to a 12-month Preexisting Condition limitation period. This limitation period will be reduced by the number of months, not to exceed 6 months, that the Insured Person was covered under any prior Creditable Coverage, including any waiting period for that coverage, in effect at any time during the 12 months before the Insured Person's effective date under this Policy.

#### IV. Benefits

A. The benefits outlined in the table below show the payment percentages for Covered Expenses AFTER each Insured Person has satisfied any deductibles. You have a choice of four plans of coverage. Plan I has a \$1000 Calendar Year Deductible; Plan II has a \$2500 Calendar Year Deductible; Plan III has a \$5,000 Calendar Year Deductible; and Plan IV has a \$7,500 Calendar Year Deductible. Individuals also eligible for Medicare may enroll in Plans I, II and III. The Calendar Year Deductible amount selected may not be changed to a lower amount after the Policy is issued. You may request to change to a higher Calendar Year Deductible, if offered by the Pool, but only one such change will be allowed in a calendar year. The change will be effective on the first of the month following the date the Pool receives Your written request for such change or a later date, if You request it.

Covered Expenses are limited to the Allowable Amount determined by the Administrator. For a Preferred (BlueChoice) Provider, the Allowable Amount is based on the terms of the Preferred Provider network contract and the payment methodology in force on the date of service. The payment methodology used may include diagnosis-related groups (DRGs), relative value, resource based relative value scale (RBRVS), fee schedules, package pricing, global pricing or other payment methodologies. For a Non-Preferred Provider, the Allowable Amount is based on the amount that would have been paid for the same covered service, supply or procedure with an equivalent Preferred Provider.

**IMPORTANT: All claim payments are based on Allowable Amounts. Preferred Providers, contracted with the Administrator, must accept these Allowable Amounts as payment in full, subject to the deductibles and Preferred Provider Coinsurance Percentage. If an Insured Person uses a Non-Preferred Provider, the Insured Person will be responsible for charges over the Allowable Amount, in addition to the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage. ParPlan Providers have agreed to accept the Allowable Amount as payment in full, subject to the Insured Person's payment of the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage.**

**Even if You consult a Preferred Provider, ask about any of the providers rendering care to You. For example, if You are scheduled for surgery, ensure that Your Preferred Provider surgeon will be using a Preferred Provider facility for Your procedure and a Preferred Provider for Your anesthesia, radiology or pathology services.**

Services You receive during an inpatient or outpatient admission may include care rendered by hospital-based, ancillary Non-Preferred Providers, such as an anesthesiologist, pathologist, radiologist, neonatologist or emergency medicine physician. To confirm if Your Preferred Provider facility includes ancillary Preferred Providers, go to "Provider Finder" at <http://www.bcbstx.com/onlineDirectory/ppo.htm> and, in the Custom Search box, click on the link at the "Important Note" to verify information for Your facility.

After each Insured Person has paid the applicable deductibles, the Policy will pay the amount of Covered Expenses in excess of the applicable coinsurance amount. After You have paid the applicable Coinsurance Maximum for each calendar year, the Policy will pay 100% of Covered Expenses for the remainder of the calendar year. In no event will the Policy pay more than the Lifetime Maximum for each Insured Person. Also, the Calendar Year Deductible, the emergency care deductible, physician office visit copayments and charges for outpatient prescription drugs, including charges applied to the prescription drug deductible or copayments, do not count toward the Coinsurance Maximums.

The Calendar Year Deductible and Coinsurance Maximums are accumulated on a calendar year basis, regardless of when Your coverage becomes effective. However, Covered Expenses, which are applied toward the Calendar Year Deductible in the last three months of the year, will also be applied in an equal amount to the Calendar Year Deductible for the next year.

Covered Expenses are charges for services and supplies, which are covered by the Policy, that are not in excess of Allowable Amounts and that are determined by the Administrator to be Medically Necessary for treatment of an illness or injury.

Lifetime Maximum or Lifetime Maximum Amount means the maximum amount of covered expenses payable by the Pool under this Policy and any other Pool policy for each Insured Person. The Lifetime Maximum Amount is \$2,000,000.

WHAT YOU PAY	PLAN I	PLAN II	PLAN III	PLAN IV
Calendar Year Deductible for each Insured Person	\$1000	\$2500	\$5000	\$7500
Coinsurance for Preferred Providers	20%	20%	20%	20%
Coinsurance for Non-Preferred Providers	40%	40%	40%	40%
Coinsurance Maximum for Preferred Providers (calendar year) for each Insured Person	\$3000	\$3000	\$3000	\$5000
Coinsurance Maximum for Non-Preferred Providers (calendar year) for each Insured Person	\$10,000	\$10,000	\$10,000	\$10,000
Lifetime Maximum Amount for each Insured Person	\$2,000,000			

## BENEFITS

Hospital	Average semi-private room rate No more than one visit per physician per day
Intensive Care or Cardiac Care Unit	No more than 3 times the average semi-private room rate
Assistant surgeon or Surgical First Assistant	One assistant, no more than 25% of the primary surgeon's fee
Hospital or other facility for Emergency Care	Subject to additional \$75 deductible per visit
Physician Office Visit ( <b>Preferred Providers Only</b> ) for covered injury or illness	\$30 copayment per visit, 5 visits per calendar year Visits after first 5, subject to Calendar Year Deductible & Coinsurance
Outpatient Therapy, including Physical, Occupational & Speech Language Therapy	Combined maximum benefit of \$2,000 per calendar year (does not apply to Acquired Brain Injury or Serious Mental Illness)
Skilled Nursing Facility	45 days per calendar year
Home Health Care	Calendar year maximum benefit of lesser of 60 visits or \$5,000
Hospice Care	Lifetime maximum benefit of lesser of 180 days or \$10,000
Ambulance	Calendar year maximum benefits of \$2,000 ground & \$5,000 air
Named Transplants	\$300,000 combined lifetime maximum benefit
Serious Mental Illness	Calendar year maximum benefit of 30 inpatient days and 50 outpatient visits
Preauthorization Provisions	If a preauthorization requirement is not met, benefits for covered expenses will be reduced 50%

**Other Benefits** (see Policy for specific benefits)

- Acquired brain injury
- Allergy tests and injections
- Anesthesia
- Blood
- Breast reconstruction in connection with mastectomy
- Breast, colorectal, cervical and prostate cancer screenings
- Complications of Pregnancy (no coverage for normal maternity)
- Diabetes equipment, supplies and self-management training
- Dietary formulas for PKU and other heritable diseases
- Durable medical equipment
- Genetic Testing and Counseling
- Growth Hormone Treatment
- Home infusion therapy
- Miscellaneous Hospital services and supplies
- Outpatient care
- Outpatient contraceptive services
- Oxygen
- Preadmission Testing
- Preventive Care
- Prosthetic devices
- Radiation therapy, inhalation therapy, chemotherapy
- Reconstructive Surgery
- Reduction Mammoplasty
- Second Surgical Opinion
- Surgeons
- Surgical services and supplies from an Ambulatory Surgical Center and Hospital outpatient facility
- X-rays and laboratory tests
- Vasectomy and tubal ligation or occlusion

**B. Preauthorization and Case Management Provisions**

The special features listed below allow You access to the medical care You need, while they reduce the costs to You and the Pool.

1. **Preauthorization:** Information is reviewed by medical personnel to authorize specific services. Preauthorization is required for the following medical services: inpatient hospital admissions; skilled nursing facility admissions; home health care visits and services; home infusion therapy; hospice care on an inpatient or outpatient basis; durable medical equipment over \$2,000, except durable medical equipment for treatment of diabetes; and organ and tissue transplants. It is necessary to contact the Administrator prior to obtaining such services. **If the service is not preauthorized, the benefit for the service will be reduced by 50%.** In addition, certain benefits administered by the Pharmacy Manager are subject to Prior Authorization. Please see the Prescription Drug benefit description for details.
2. **Case management:** The case manager will work with You and Your physician to determine the appropriate level of care You need.

**C. BlueChoice® Network**

The Pool has selected the BlueChoice® Network as the Pool's Preferred Provider Organization (PPO). Although You may choose any medical provider or hospital, You will save money by using providers from the BlueChoice® Network.

If You choose a BlueChoice provider, the Policy will pay a greater coinsurance rate and the BlueChoice provider's rate will be based on the Allowable Amount for that provider's service. If You choose a medical provider or hospital not participating in the BlueChoice® Network, the Policy will pay a lower coinsurance rate for covered expenses. Also, Covered Expenses of Non-Preferred Providers, paid by the Policy, will be based on the Allowable Amount, determined by the Administrator, which may be less than the provider's billed rate. The provider may bill You for the difference between the charges paid by the Policy and the provider's billed rate (balance billing). If this occurs, You will have a greater out of pocket expense. If You choose a ParPlan Provider, the Policy will pay the Non-Preferred Provider level of benefits, but the ParPlan Provider has agreed to: file Your claims; not bill You for the difference between the ParPlan Provider's charge and the Allowable Amount covered under this Policy for any treatment or services; and not bill You for treatment or services that are not Medically Necessary, as determined by the Administrator.

There are other advantages to using BlueChoice providers. They will handle the initial paperwork so You do not have to file claims. They may also preauthorize benefits for You, although it is ultimately Your responsibility to ensure that Your services have been authorized by the Pool.

A list of Preferred Providers in Your area is contained in the Preferred Provider Directory that was provided to You. You may call the Administrator's preauthorization referral department at its toll free number, 1-888-398-3927, to obtain the name of a Preferred Provider outside Your area, if needed. Any changes to the list of Preferred Providers will be made available to You not less than annually. You may call the Administrator during regular business hours to receive a current list of Preferred Providers. The list of Preferred Providers changes from time to time so it is important for You to verify the network status of Your providers.

You can do this by confirming with Your provider that the provider is a member of the network or by calling the Administrator or checking the list of current Preferred Providers found on the Pool's web site ([www.txhealthpool.org](http://www.txhealthpool.org)).

If there are no BlueChoice providers available to You, You must contact the Administrator's preauthorization referral department at its toll free number. Generally, a BlueChoice provider will be considered to be unavailable to You if You reside more than 30 miles from a BlueChoice provider. If there are no BlueChoice providers available to You and You receive approval from the Administrator before obtaining services from a Non-Preferred Provider, Covered Expenses for treatment or services by the Non-Preferred Provider will be paid at the Preferred Provider coinsurance level. If You fail to obtain approval from the Administrator prior to obtaining the services of a Non-Preferred Provider, Covered Expenses for treatment or services by that Non-Preferred Provider will be paid at the Non-Preferred Provider Coinsurance Percentage, regardless of the availability to You of a Preferred Provider.

When an Insured Person receives covered Emergency Care Services from a Non-Preferred Provider, those services will be paid as if they were received from a Preferred Provider. However, once the Insured Person can be safely transferred to a Preferred Provider, the Insured Person must be transferred to a Preferred Provider in order to continue receiving the Preferred Provider level of benefits. If the Insured Person chooses not to transfer, Policy benefits will be payable at the lower Non-Preferred Provider level.

**IMPORTANT: All claim payments are based on Allowable Amounts. Preferred Providers, contracted with the Administrator, must accept these Allowable Amounts as payment in full, subject to the deductibles and Preferred Provider Coinsurance Percentage. If an Insured Person uses a Non-Preferred Provider, the Insured Person will be responsible for charges over the Allowable Amount, in addition to the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage. ParPlan Providers have agreed to accept the Allowable Amount as payment in full, subject to the Insured Person's payment of the deductibles and the Insured Person's share of the Non-Preferred Provider Coinsurance Percentage.**

**Even if You consult a Preferred Provider, ask about any of the providers rendering care to You. For example, if You are scheduled for surgery, ensure that Your Preferred Provider surgeon will be using a Preferred Provider facility for Your procedure and a Preferred Provider for Your anesthesia, radiology or pathology services**

**Services You receive during an inpatient or outpatient admission may include care rendered by hospital-based, ancillary Non-Preferred Providers, such as an anesthesiologist, pathologist, radiologist, neonatologist or emergency medicine physician. To confirm if Your Preferred Provider facility includes ancillary Preferred Providers, go to "Provider Finder" at <http://www.bcbstx.com/onlinedirectory/ppo.htm> and, in the Custom Search box, click on the link at the "Important Note" to verify information for Your facility.**

If an Insured Person's Preferred Provider's arrangement with the Network, chosen by the Pool for this Policy, terminates and, at the time of such termination, the Insured Person has special circumstances, benefits for Covered Expenses received from that provider will be paid as if the Covered Expenses were received from a Preferred Provider until: in the case of an Insured Person who has been diagnosed with a terminal illness, the end of nine months after the effective date of termination; in the case of an Insured Person who, at the time of termination, is past the 24th week of pregnancy, delivery of the child, immediate post-partum care and the follow-up checkup within the first six weeks after the delivery; or in all other special circumstances, the end of 90 days after the date of termination.

"Special circumstances" means a condition such that the treating Physician reasonably believes that discontinuing care by the treating Physician could cause harm to the patient. Special circumstances must be identified by the treating Physician who must: make a request to the Administrator that the Insured Person be permitted to continue treatment under the Physician's care; and agree not to seek payment from the Insured Person for any amounts in excess of the Preferred Provider rate for the treatment or services rendered.

#### **D. BlueCard Program**

The BlueCard Program provides access to Preferred Providers of other Blue Cross and/or Blue Shield Plans outside Texas. If You incur expenses outside Texas through the BlueCard Program, You must pay the Preferred Provider Coinsurance amount, after satisfaction of the Deductible. Covered Expenses for a BlueCard program provider will be calculated using the lesser of the billed charges of the BlueCard Program provider or the negotiated rate the Administrator pays the local Blue Cross and/or Blue Shield Plan.

#### **E. Pharmacy Benefits**

**This benefit does not apply to an Insured Person eligible for Medicare.** The Pool offers a statewide network of pharmacies, a Mail Order program and a Specialty Medications program through Medco Health Solutions, Inc., the Pharmacy Manager. To ensure proper dosage and use, some prescription drugs may be subject to a quantity limit per prescription and/or per 30-day supply. Certain drugs will require prior authorization by the Pharmacy Manager before You can obtain a covered prescription drug at a network pharmacy. A list of the drugs, including growth hormone drugs and rheumatoid arthritis agents, that require prior authorization can be obtained on the Pool web site, [www.txhealthpool.org](http://www.txhealthpool.org), or by calling the Pharmacy Manager's toll free number shown on the first page of this Outline of Coverage. Compounded drugs and branded generic drugs will be covered as brand name drugs. The copayment You will pay for a compounded drug will be based on the classification of the highest cost ingredient in the compounded drug.

##### **1. Prescription Drug Deductible**

Benefits for outpatient prescription drugs are subject to a calendar year deductible of \$200 for Plans I, II and III and of \$500 for Plan IV. Charges applied to this deductible or to the applicable drug Copayments do not apply to the Calendar Year Deductible or to the Coinsurance Maximum amount.

##### **2. Pharmacy Network Benefits**

When Your prescriptions are filled at a network pharmacy, for up to a 30-day supply, You will pay \$10 for generic drugs, or, if a generic drug is not available, \$25 for formulary brand name drugs or the greater of \$40 or 50% of the drug cost for non-formulary brand name drugs. If a generic drug is available and You receive a brand name drug, You will pay the applicable brand name drug Copayment plus the difference in cost between the generic drug and the brand name drug. For Specialty Medications, You will pay \$100 for each 30-day prescription.

The Pool also offers a Mail Order program through the Pharmacy Manager. When Your prescriptions are filled through the Mail Order program, for up to a 90-day supply, You will pay \$25 for generic drugs, or if a generic drug is not available, \$60 for formulary brand name drugs or the greater of \$100 or 50% of the drug cost for non-formulary brand name drugs. If a generic drug is available and You receive a brand name drug, You will pay the applicable brand name drug Copayment plus the difference in cost between the generic drug and the brand name drug.

The Pool also offers a Specialty Medications program through the Pharmacy Manager for Insured Persons who are receiving treatment for complex disease states. Specialty medications, obtained through the program, will be subject to the Prescription Drug Deductible, if not met and the Specialty Medications Copayment and will not exceed a 30-day supply.

##### **3. Non-Network Pharmacy Benefits**

When You fill a prescription at a non-participating pharmacy, You must pay the charges of the pharmacy and submit a claim to the Pharmacy Manager. After deduction of the Prescription Drug Deductible, if not met, and the applicable Copayment, the Pharmacy Manager will pay a benefit equal to 90% of the lesser of the pharmacy's usual and customary charge or the amount that would have been paid by the Policy for the same prescription if dispensed by a network pharmacy. A covered prescription will not exceed a 30-day supply.

#### **V. Insured Person's Financial Responsibility**

The Insured Person is financially responsible for: payment of premiums on a timely basis; payment to health care providers for charges that are applied to the calendar year deductible, Prescription Drug Deductible or emergency care deductible; payment to health care providers for the balance of charges after the Pool's payment of the Coinsurance Percentage; copayment amounts; balance of charges, if any, between Allowable Amounts and a Non-Preferred Provider's billed rate; any charges that are not a Covered Expenses payable under the Policy; any charges for services or treatment excluded under the Policy; and amounts in excess of benefit maximum amounts.

#### **VI. Subrogation and Reimbursement**

The Pool has a right to subrogation and reimbursement, as outlined in the Policy and §§1506.301-1506.305, Texas Insurance Code.

## **VII. Right to Recover an Overpayment**

If the Pool makes any overpayment, the Pool can recover what it did not owe from the person to whom the payment was made or from any other appropriate person. The Pool has this right even if the mistake was the Pool's fault. If the overpayment was made to You, the Pool has the right to deduct it when the Pool pays Your claims.

## **VIII. Exclusions and Limitations**

- A.** The Policy will not pay benefits for services or expenses or any loss resulting from or in connection with:
1. Services, supplies or treatment provided: prior to the Effective Date of coverage or after the termination date of coverage for an Insured Person; or for the portion of any Hospital or other inpatient facility admission that occurs before the Effective Date of coverage or after the termination date of coverage for an Insured Person.
  2. Any service or supply that is not medically necessary.
  3. Charges for treatment, services or supplies that are Experimental or Investigational in nature.
  4. Any expense determined by the Pool to be in excess of the Allowable Amount.
  5. Any penalty or fee for the failure to keep a scheduled visit with a Physician; or any charges for completion of any insurance forms or for acquisition of medical records.
  6. Any charge for services or supplies that are not within the scope of authorized practice of the institution or person rendering the services or supplies.
  7. Any charges for physical therapy, occupational therapy or speech language therapy provided by an educational institution or school district.
  8. Elective procedures, treatments or medications therefor, including but not limited to, abortions, sterilization reversals, sexual transformations, sexual dysfunctions, sexual inadequacies or disorders, or treatment for impotence.
  9. Any treatment provided by an Immediate Family Member of an Insured Person, except as provided for diabetes self-management training.
  10. Any loss to which a contributing cause was the Insured Person's being engaged in an illegal occupation or activity, or commission of or attempt to commit a felony.
  11. War or any act of war, declared or undeclared; or participation in a riot, insurrection or rebellion.
  12. Injury or Sickness, regardless of cause, if charges are incurred while serving in the armed forces or auxiliary units. Premium will be refunded on a pro rata basis for any Insured Person who enters military service; all coverage for that person will be suspended until military service is over.
  13. Any loss for which Worker's Compensation or Employer's Liability or Occupational Disease Benefits are payable.
  14. Cosmetic or reconstructive surgery, except as provided in the Benefits Provisions. Surgery performed to treat a mental, emotional or nervous disorder through change in appearance is considered a cosmetic surgery for purposes of this exclusion.
  15. Bariatric surgical procedures or complications related to such surgeries, even if the Insured Person has other health conditions that are related to, caused by or impacted by excess weight, obesity or morbid obesity, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
  16. Aviation of any type, except for an air ambulance when medically necessary or as a passenger on a regularly scheduled flight on a commercial airline.
  17. Charges incurred outside the United States if the Insured Person traveled to the location for the purposes of receiving medical services, drugs or supplies.
  18. Care received in Veterans Administration Hospitals or facilities for a service-connected disability.
  19. Services or treatment provided in a government hospital unless there is a legal obligation to pay in the absence of insurance. This does not exclude coverage for the treatment of mental health and mental retardation provided by a tax supported institution of the state of Texas, including community centers for mental health and mental retardation services, provided charges are regularly and customarily charged to non-indigent patients and if benefits under this Policy would otherwise be provided.
  20. Services or treatment for which the Insured Person is not legally required to pay, except Medicaid.
  21. Personal items such as TV, admitting kits, cots for Immediate Family Members, guest meals and other items that are not Medically Necessary.
  22. Any dental services or supplies except as necessitated by accidental Injury. Covered Expenses must be incurred within 12 months of the date of Injury. Injuries caused by chewing or biting down are excluded.
  23. Eyeglasses, contact lenses, hearing aids or the examination for prescription or fitting thereof, radial keratotomy or any eye surgery solely for the purpose of correcting refractive defects; treatment of myopia and other errors of refraction; orthoptics or visual training.
  24. Alcoholism or drug addiction.
  25. Any service or supply to eliminate or reduce a dependency on or addiction to tobacco or a controlled substance.
  26. Charges as a result of suicide or intentionally self-inflicted Injury or Illness, while sane or insane.
  27. Overdose of or illness or injury resulting from use of drugs, narcotics, hallucinogens, controlled or uncontrolled substances, unless administered on and according to the advice of a Physician.

28. Illness or Injury to which a contributing cause was the Insured Person's being under the influence of or resulting from the use of intoxicants, including but not limited to, alcoholic pancreatitis, alcoholic hepatitis or alcoholic cirrhosis of the liver.
29. Any service or supply associated with an autopsy or postmortem examination unless requested by Us.
30. Private duty nursing services, except as provided in the Home Health Care benefit in the Benefits Provisions.
31. Any service or supply in connection with the diagnosis or treatment of infertility, male or female, and any form or attempt of artificial fertilization or implantation, including artificial insemination, in-vitro fertilization, and gamete intra-fallopian transfer.
32. Augmentation or reduction mammoplasty, except as provided in the Benefits Provisions, or removal of prosthetic devices, except in the case of cancer.
33. Room and board charges incurred during a Hospital admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient basis without adversely affecting the Insured Person's physical condition or the quality of medical care provided.
34. Charges incurred in connection with a Hospital or other inpatient stay primarily for environmental change, physical therapy, custodial care or rest cures.
35. Transportation, except as provided for ambulance services in the Miscellaneous Services benefit in the Benefits Provisions.
36. Any service or supply for the diagnosis or treatment of temporomandibular joint dysfunction, unless due to accidental Injury.
37. Any service or supply received by an Insured Person as a result of or in connection with a court order, except a medical support order requiring coverage for a dependent child.
38. Any service or supply in connection with routine foot care, including the removal of warts, corns or calluses, the cutting and trimming of toenails, or foot care for flat feet, fallen arches, chronic foot strain, or symptomatic complaints of the feet in the absence of severe systemic disease; or any arch supports, orthopedic shoes or support hose, or similar type devices/appliances regardless of intended use, unless such use is for prevention of amputation in connection with treatment of diabetes.
39. Any occupational therapy services that do not consist of traditional physical therapy modalities and that are not part of any active multi-disciplinary physical rehabilitation program designed to restore lost or impaired bodily function.
40. Any medical social services or vocational counseling.
41. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
42. Confinement or treatment in any convalescent home, sanitarium, convalescent rest or nursing facilities or facilities primarily affording custodial or educational care or facilities for the aged, except as specifically provided in the Skilled Nursing Facility benefit in the Benefits Provisions.
43. Any service or supply used for preventive care, except preventive care provided for chronic illness, cancer or HIV/AIDS or as specifically provided in the Benefits Provisions.
44. Any service or supply provided for inpatient or outpatient mental health, except as specifically provided for treatment of Serious Mental Illness in the Benefits Provisions.
45. Any service or supply provided for prescription drugs, except as specifically provided in the Benefits Provisions.
46. Nutritional counseling or food supplements, except as provided for Home Infusion Therapy or treatment of Phenylketonuria (PKU) or other heritable diseases in the Benefits Provisions.
47. Growth hormone drugs or treatments, except as provided in the Benefits Provisions.
48. Hemophilia factor drugs, except as provided in the Benefits Provisions.
49. Immune Globulins, Infused Rheumatoid Arthritis drugs, Alpha-1 therapy drugs and drugs to treat Fabry's disease, except as provided for Specialty Medications in the benefit for Prescription Drugs or if provided during an inpatient Hospital confinement.
50. Any services for transplants or replacements, except as specifically provided in the Benefits Provisions.
51. Genetic testing or counseling, except as provided in the Benefits Provisions, biofeedback, travel expenses, holistic therapies, acupuncture, hypnosis or massage therapy.
52. Any services, supplies or medications used for the primary purpose of evaluation for or diagnosis or treatment of the condition known as Idiopathic Environmental Intolerance (IEI) or Multiple Chemical Sensitivities (MCS) or Environmental Sensitivities (ES) or any other term by which these conditions may be known.
53. Charges for pregnancy or maternity care, including but not limited to normal deliveries, elective caesarean sections and elective abortions, except as provided for Complications of Pregnancy.
54. Charges for Vagus Nerve Stimulation (VNS), except for treatment of partial-onset seizures refractory to medical therapy.

**B.** In addition to those exclusions, Covered Expenses under the Prescription Drug benefit for prescription drugs will not include charges for:

1. Outpatient prescription drugs and medicines, devices, equipment and supplies of any kind provided to an Insured Person eligible for Medicare.
2. Drugs or medications that have an over-the-counter equivalent or that can be lawfully obtained without a Physician's prescription, except insulin and insulin analogs.
3. Any charge incurred for the administration of prescription drugs by a Physician.
4. Drugs and substances that are Experimental or Investigational in nature.

5. Drugs taken or given while an Insured Person is confined on an inpatient or outpatient basis in a Hospital, extended care facility, Skilled Nursing Home or similar institution that has a facility for providing drugs.
6. Replacement of lost, stolen, destroyed or damaged prescriptions.
7. Vitamins that do not require a Prescription Order or have an FDA approved indication to treat a medical condition, or for which there is a non-prescription alternative;
8. Dietary supplements, cosmetic, health and beauty aids.
9. Charges for drugs in excess of the Pharmacy Allowable Charges in the area where the drugs are dispensed.
10. Therapeutic devices or appliances, support garments and other non-medical items regardless of their intended use, except as provided for treatment of diabetes.
11. Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair or otherwise.
12. Cosmetic drugs, except for acne medication, including Retin-A, Accutane, Avita and Differin, for an Insured Person under age 30 for treatment of acne vulgaris.
13. Smoking cessation products.
14. Blood and blood plasma.
15. Appetite suppressants or any other drugs prescribed for weight loss.
16. Injectable drugs for treatment of allergies.
17. Infertility medications.
18. Drugs or medications for treatment of sexual dysfunctions or disorders.
19. Biological sera.
20. Drugs or medications prescribed for an Injury or Illness arising out of employment.
21. Drugs or medications furnished by any government organization or agency unless there is an unconditional legal obligation on the part of the Insured Person to pay such expenses, except Medicaid.
22. Prescription Orders written by Physicians located outside the United States to be dispensed in the United States.
23. Drugs or medications prescribed for treatment of Chemical Dependency.
24. Drugs, including abortifacients, or devices intended to terminate a pregnancy.

**IX. Definitions:**

Church Plan has the meaning assigned by Section 3(33), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002 (33)).

Creditable Coverage means, with respect to an individual, coverage of the individual provided under any of the following: a Group Health Plan; a Health Benefit Plan; Part A or Part B, Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.) (Medicare); Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) (Medicaid), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s) (the program for pediatric vaccines); 10 U.S.C. Section 1071 et seq. (Uniformed Services Former Spouses' Protection Act); a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a health plan offered under 5 U.S.C. Section 8901 et seq. (Federal Employees Health Benefits Act of 1959); a public health plan as defined in federal regulations; a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)); a state child health plan provided under Title XXI, Social Security Act (State Children's Health Insurance Program) and short-term limited duration coverage (Health Benefit Plan coverage that has a specified contract expiration date within 12 months of the effective date of the contract, including any extensions that may be elected by the insured without the insurance company's consent)..

Creditable Coverage does not include coverage under: accident-only insurance (including accidental death and dismemberment insurance); disability income insurance or a combination of accident-only and disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit only insurance (including mortgage insurance); coverage for onsite medical clinics; other coverage that is similar to the coverage under which benefits for medical care are secondary or incidental to other insurance benefits and as specified by federal regulations; if offered separately, coverage that provides limited scope dental or vision benefits; if offered separately, long term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community based care coverage or benefits or any combination of those coverages or benefits; if offered separately, coverage that provides other limited benefits as specified by federal regulations; if offered as independent, non coordinated benefits, coverage for specified disease or illness; if offered as independent, non coordinated benefits, hospital indemnity or other fixed indemnity insurance; or Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C Section 1395ss) (Medicare and Medicaid Patient and Program Protection Act of 1987); coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. Section 1071 et seq.) (Uniformed Services Former Spouses' Protection Act), and similar supplemental coverage provided under a group plan, but only if such insurance or coverages are provided under a separate policy, certificate or contract of insurance.

Dependent means a person, under age 65, whose primary residence is with You and who is described below:

Your spouse;

Your unmarried child or step-child who is under age 25;

Your unmarried stepchild who is under age 25;

An unmarried child adopted by You, including a child You are seeking to adopt, who is under age 25, for the first 31 days from the date of adoption or initiation of adoption. After 31 days, such child will remain a Dependent under this Policy only if We receive notice of the adoption or initiation of the suit before the next premium due date following the 31 days after adoption or initiation of suit and the required premium is paid;

Your unmarried grandchild who is dependent on You for Federal income tax purposes and under age 25 (coverage for a grandchild will not terminate solely because the Insured child is no longer Your dependent for Federal income tax purposes);

A child of any age who is disabled and dependent on You; and

A newborn child born to You for the first 31 days after birth. After 31 days, such child will remain a Dependent under this Policy only if We receive notice of birth before the next premium due date, following the 31 days after birth and the required premium is paid.

Dependent also means an unmarried child, under age 25 for whom You have received a court or administrative order to provide medical support, including Health Benefit Plan coverage.

Family Member means a parent, step-parent, grandparent, brother or sister of a child who is an eligible individual, provided the Family Member resides with the child.

Federally Defined Eligible Individual means an individual who meets all of the following requirements:

1. As of the date on which the individual applies for Pool coverage, the individual's aggregate period of prior Creditable Coverage is 18 months or more;
2. The individual's most recent prior creditable coverage was under a Group Health Plan, Church Plan or Governmental Plan;
3. The individual is not eligible for coverage under a Group Health Plan, Part A or Part B, Title XVIII, Social Security Act (42 U.S.C. Section 1395c et seq.) or a state plan under Title XIX, Social Security Act (42 U.S.C. Section 1396 et seq.) or any successor program and who does not have other Health Benefit Plan coverage;
4. The most recent Creditable Coverage was not terminated for fraud or for nonpayment of premiums or contributions;
5. If offered, the individual elected and exhausted continuation coverage under the Texas Insurance Code or under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), as applicable.

Governmental Plan has the meaning assigned by Section 3(32), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002 (3)), and includes any United States governmental plan.

Group Health Plan means an employee welfare benefit plan as defined by Section 3(1), Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002 (1)), to the extent that the plan provides health benefit plan coverage to employees or their dependents as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise.

Health Benefit Plan means: an individual or group health benefit plan and includes: a hospital or medical expense incurred policy; coverage of medical or health care services offered by a group hospital service corporation operating under Chapter 842, Texas Insurance Code; a fraternal benefit society operating under Chapter 885, Texas Insurance Code; a stipulated premium company operating under Chapter 884, Texas Insurance Code; a health maintenance organization; a multiple employer welfare arrangement subject to Chapter 846, Texas Insurance Code; an approved nonprofit health corporation that holds a certificate of authority under Chapter 844, Texas Insurance Code; or any other health care plan or arrangement that pays for or furnishes medical or health care services by insurance or otherwise.

Health Benefit Plan does not include:

1. One or more or any combination of the following:
  - coverage only for accident or disability income insurance or any combination of those coverages;
  - credit-only insurance;
  - coverage issued as a supplement to liability insurance;
  - liability insurance, including general liability insurance and automobile liability insurance;
  - workers' compensation or similar insurance;
  - coverage for on-site medical clinics;
  - automobile medical payment insurance;
  - insurance coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in a liability insurance policy or equivalent self-insurance; or

other similar insurance coverage, specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), under which benefits for medical care are secondary or incidental to other insurance benefits;

2. The following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the coverage:
  - limited scope dental or vision benefits;
  - benefits for long-term care, nursing home care, home health care, community-based care, or any combination of these benefits; or
  - other similar, limited benefits specified by federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191); or
3. The following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
  - coverage only for a specified disease or illness;
  - hospital indemnity or other fixed indemnity insurance.

Insurance Company means: an insurance company; a health maintenance organization; an approved nonprofit health corporation; a fraternal benefit society; a stipulated premium insurance company; a group hospital service corporation; a multiple employer welfare arrangement; or any other entity providing a plan of Health Insurance or health benefits subject to state regulation.

Significant Break in Coverage means a period of 63 consecutive days during all of which the individual does not have Health Benefit Plan coverage, except that a waiting period or an affiliation period is not considered in determining a Significant Break in Coverage.

## **X. Renewability and Termination**

### **A. Renewal**

The Policy will be renewed each time the required premium payment is made on a timely basis.

### **B. Termination**

Coverage will terminate for each person insured under this Policy:

1. 31 days after the day on which a premium payment for the Policy becomes due if payment is not made before that date; or
2. the earlier of the premium due date or the first day of the month that follows the date on which the Pool determines:
  - a. the person is no longer eligible for coverage under the Pool; or
  - b. the person is no longer a resident of the state of Texas, except for: a child who is a student under the age of 25 and financially dependent upon You; a child for whom You have received a court or administrative order to provide medical support, including Health Benefit Plan coverage; or a child of any age who is disabled and dependent on You; or
  - c. the person is 65 years old (does not apply to an Insured Person enrolled as a Federally Defined Eligible Individual, if that person is not eligible for Medicare or to an Insured Person enrolled under the HCTC program, if that person is not enrolled in Medicare Part B); or
3. 30 days after the date the Pool or its Administrator makes inquiry concerning the person's place of residence or any other eligibility criteria and the person does not reply; or
4. on the first day of the month that follows the primary insured's request for termination of coverage;
5. on the date of the person's death; or
6. on the date state law requires cancellation of this Policy.

## **XI. Premiums**

Premiums for the Pool may be paid monthly (by Automatic Bank Withdrawal), quarterly, semi-annually, or annually. Premium rates are based on Your age, gender, zip code, tobacco use and Medicare eligibility status. These rates are subject to change with at least 30 days notice. An initial premium payment for amount of the premium payment method selected must be submitted with an application for the Policy. A grace period of 31 days is allowed for the payment of premium, subject to the Renewability and Termination provisions above. We reserve the right to deduct the amount of any unpaid premium from any benefits paid to You or on Your behalf for charges incurred during the grace period.

## **XII. Complaints**

If You have a complaint about the Pool, please contact the Administrator at its toll free number for the procedures for filing complaints. The Pool will not retaliate against any Insured Person because a complaint is filed by or on behalf of that person.