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OCT 25 2022



Montgomery County, Texas

Montgomery County Employee Medical Plan

Plan Document and Summary Plan Description

Effective: January 01, 1989

Restated: January 01, 2023

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), established by **Montgomery County, Texas** (the "County", "Montgomery County", "Employer" or the "Plan Sponsor pursuant to Chapters 172 and 175 of the Texas Local Government Code, as of January 01, 2023, hereby sets forth the provisions of the Montgomery County Employee Medical Plan (the "Plan"), which was originally adopted by the County by and through its Commissioners Court effective January 01, 1989. Any wording which may be contrary to Federal Laws or applicable State Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or applicable State Statutes which mandate a change to the Plan are also automatically deemed a part of the Plan, to the extent required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document supersedes and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Date:

10/25/2022

Montgomery County, Texas



Mark J. Keough, County Judge

ABSENT

Robert C. Walker, Commissioner Pct. 1

ABSENT

Charlie Riley, Commissioner Pct. 2


James Noack, Commissioner Pct. 3


James Meets, Commissioner Pct. 4

TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION	2
TABLE OF CONTENTS.....	3
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION.....	4
DEFINITIONS.....	7
ELIGIBILITY FOR COVERAGE.....	24
TERMINATION OF COVERAGE.....	32
CONTINUATION OF COVERAGE.....	34
GENERAL LIMITATIONS AND EXCLUSIONS.....	41
PLAN ADMINISTRATION.....	44
COST CONTAINMENT INCENTIVES.....	46
CLAIM PROCEDURES; PAYMENT OF CLAIMS.....	47
COORDINATION OF BENEFITS.....	56
MEDICARE.....	59
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT.....	60
MISCELLANEOUS PROVISIONS.....	65
SUMMARY OF BENEFITS.....	68
MEDICAL BENEFITS.....	81
UTILIZATION MANAGEMENT.....	90
CARE NAVIGATION (A Medical Tourism Program).....	93
PRESCRIPTION DRUG BENEFITS.....	94
HIPAA PRIVACY.....	97
HIPAA SECURITY	100

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees, Retirees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund established by the Plan Sponsor with contributions from Participants and/or the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees, Retirees and their Dependents against certain health expenses and to help defray the financial effects arising from Injury or Illness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Participants in the Plan to the maximum feasible extent.

The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by **Montgomery County** and may be reviewed at any time during normal working hours by any Participant.

General Plan Information

Grandfathered Health Plan

This group health plan believes this plan is a "Grandfathered Health Plan" under the Affordable Care Act (ACA). As permitted by the Affordable Care Act, a Grandfathered Health Plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered Health Plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to Other Plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, Grandfathered Health Plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a Grandfathered Health Plan and what might cause a plan to change from Grandfathered Health Plan status can be directed to the Plan Administrator at the following address:

Montgomery County
501 North Thompson, Suite 202
Conroe, Texas 77301

Participants may also contact the U.S. Department of Health and Human Services at www.hhs.gov. In addition, the following website has additional information regarding Grandfathered Health Plans: <https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/>.

Name of Plan:

Montgomery County Employee Medical Plan

Plan Sponsor:

Montgomery County, Texas
501 North Thompson, Suite 202
Conroe, Texas 77301
Phone: 1-936-760-6935
Fax: 1-936-538-8169
Website/Email: <https://risk.mctx.org/medical.aspx>

Plan Administrator:

Director, Department of Risk Management
Montgomery County, Texas

501 North Thompson, Suite 202
Conroe, Texas 77301
Phone: 1-936-760-6935
Fax: 1-936-538-8169
Website/Email: <https://risk.mctx.org/medical.aspx>

Plan Sponsor ID No. (EIN):
74-6000558

Source of Funding:
Self-Funded

Plan Status:
Grandfathered

Applicable Law:
Federal and applicable State of Texas laws

Plan Year:
January 1-December 31

Plan Type:
Medical
Prescription Drug

Third Party Administrator:
Boon-Chapman Benefit Administrators, Inc.
PO Box 9201
Austin, Texas 78766
Phone: 1-800-252-9653
Fax: 1-512-459-1592
Website/Email: www.boonchapman.com

Prescription Drug Plan Administrator:
MaxorPlus
320 South Polk Street, Suite 200
Amarillo, Texas 79101
Phone: 1-800-687-0707
Fax: 1-806-324-5493
Website/Email: www.maxorplus.com

Maxor Specialty Pharmacy
1-866-629-6779

Agent for Service of Process:
Montgomery County, Texas
County Judge
501 North Thompson, Suite 202
Conroe, Texas 77301
Phone: 1-936-760-6935
Fax: 1-936-538-8169

Utilization Review Manager:
Prime Dx
PO Box 9201
Austin, Texas 78766
1-800-477-4625
Fax: 1-800-213-5108

The Plan shall take effect for each Participating Employee on the Effective Date, unless a different date is set forth above opposite such Participating Employee's name.

Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Agent for Service of Process.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the County and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the County or to interfere with the right of the County to discharge any Employee at any time.

Non-Discrimination

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

Applicable Law

This Plan is a non-federal governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a Federal law regulating Employee welfare and pension plans. The Participants' rights in the Plan are governed by the plan documents and applicable Texas State law and regulations.

Discretionary Authority

To the extent allowed by law, the Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

Notwithstanding the above, the Plan may be subject to certain federal external review process requirements to the extent made applicable and required by 45 C.F.R. 147.136. See the section titled "CLAIM PROCEDURES; PAYMENT OF CLAIMS" for additional details.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for further information.

1. **"Accident"**
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.
2. **"Accidental Bodily Injury" or "Accidental Injury"**
"Accidental Bodily Injury" or "Accidental Injury" shall mean an injury sustained as the result of an Accident, due to an outside traumatic event, or due to exposure to the elements.
3. **"Actively at Work" or "Active Employment"**
An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment, including associated leave(s), in accordance with the Montgomery County Employee Policy Manual, as updated. An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment. Elected Officials are considered in active service during their term of office. Elected Officials are not required to satisfy any actively at-work provisions during their term of office.
4. **"ADA"**
"ADA" shall mean the American Dental Association.
5. **"Adverse Benefit Determination"**
"Adverse Benefit Determination" shall mean any of the following:
 1. A denial in benefits.
 2. A reduction in benefits.
 3. A rescission of coverage, even if the rescission does not impact a current claim for benefits.
 4. A termination of benefits.
 5. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
 6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review.
 7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

Explanation of Benefits (EOB)

"Explanation of Benefits" shall mean a statement a health plan sends to a Participant which shows charges, payments and any balances owed. It may be sent by mail or e-mail. An Explanation of Benefits may serve as an Adverse Benefit Determination.

6. **"Affordable Care Act (ACA)"**
The "Affordable Care Act (ACA)" means the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final,

amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

7. **"AHA"**

"AHA" shall mean the American Hospital Association.

8. **"Allowable Expense(s)"**

"Allowable Expense(s)" shall mean the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

9. **"Alternate Recipient"**

"Alternate Recipient" shall mean any Child of a Participant who is recognized under a Medical Child Support Order or other applicable statute as having a right to enrollment under this Plan as the Participant's eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

10. **"AMA"**

"AMA" shall mean the American Medical Association.

11. **"Ambulatory Surgical Center"**

"Ambulatory Surgical Center" shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s). The patient is typically admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight.

12. **"Appointed Official"**

Appointed Official means a person that is appointed to serve Montgomery County and that by virtue of their office is entitled to participate and meet the requirements under the "Eligibility for Coverage" section for Appointed Official participation.

13. **"Calendar Year"**

"Calendar Year" shall mean the 12 month period from January 1 through December 31 of each year.

14. **"Cardiac Care Unit" (or "Intensive Care Unit")**

"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention because of their critical condition.
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital.
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area.
4. It contains at least two beds for the accommodation of critically ill patients.
5. It provides at least one professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

15. **"CDC"**

"CDC" shall mean Centers for Disease Control and Prevention.

16. **"Center(s) of Excellence"**

"Center(s) of Excellence" shall mean medical care facilities and/or surgical centers that have met stringent criteria for quality care in the specialized procedures, such as organ transplantation. These centers have demonstrated that they have the greatest experience in performing these specific procedures and the best survival rates compared to other facilities offering the same or similar services. The Plan Administrator shall determine what Network Centers of Excellence are to be used by Plan Participants and may amend or expand the list as necessary to promote patient safety and cost containment goals.

Transplant Centers:

Any Participant in need of an organ transplant may contact the Third Party Administrator to initiate the Pre-certification process resulting in a referral to a Transplant Center of Excellence. The Third Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence for service where the Plan has adopted a Center of Excellence program, the payment for services will be limited to the Plan's routine and applicable coverages as per Plan provisions.

Additional information about this option and programs offered, as well as a list of Centers of Excellence for each program, will be given to covered Employees and updated as requested.

17. **"Certified IDR Entity"**

"Certified IDR Entity" shall mean Certified Independent Dispute Resolution Entity, which is an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

18. **"Child" and/or "Children"**

"Child" and/or "Children" shall mean the Employee's natural Child, any stepchild, legally adopted Child, or any other Child for whom the Employee and Spouse has been named legal guardian. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993. A "legal guardian" is a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

19. **"CHIP"**

"CHIP" refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

20. **"CHIPRA"**

"CHIPRA" refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

21. **"Chiropractic Care"**

"Chiropractic Care" shall mean the detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

22. **"Claim Determination Period"**

"Claim Determination Period" shall mean each Calendar Year.

23. **"Claimant"**

"Claimant" shall mean a Participant of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an Adverse Benefit Determination.

24. **"Clean Claim"**

A "Clean Claim" is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular

circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Participant has failed to submit required forms or additional information to the Plan as well.

25. **"CMS"**
"CMS" shall mean Centers for Medicare and Medicaid Services.
26. **"COBRA"**
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
27. **"Coinsurance"**
"Coinsurance" shall mean a cost sharing feature of many plans which requires a Participant to pay out-of-pocket a prescribed portion of the cost of Covered Expenses. The defined Coinsurance that a Participant must pay out-of-pocket is based upon his or her health plan design. Coinsurance is established as a predetermined percentage of the Maximum Allowable Charge for covered services and usually applies after a Deductible is met in a Deductible plan.
28. **"Commissioners Court" or "Montgomery County Commissioners Court"** shall mean the governing body of Montgomery County, Texas/Plan Sponsor.
29. **"Copayment" or "Copay"**
"Copayment" or "Copay" shall mean a dollar amount per visit the Participant pays to the Provider for health care expenses. In most plans, the Participant pays this after he or she meets his or her Deductible limit.
30. **"Cosmetic Surgery"**
"Cosmetic Surgery" shall mean any expenses incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury or for mitigation of pain following a Medically Necessary treatment.
31. **"Covered Expense(s)"**
"Covered Expense(s)" shall mean a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage in accordance with this Plan.

All treatment is subject to benefit payment maximums shown in the Summary of Medical Benefits and as set forth elsewhere in this document.
32. **"Custodial Care"**
"Custodial Care" shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

33. **"Deductible"**

"Deductible" shall mean an aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments.

34. **"Dentist"**

"Dentist" shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

35. **"Dependent"**

"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one who is divorced or Legally Separated from the Employee. A Dependent spouse shall include a common law spouse, when such marital status is legally recognized in the jurisdiction in which the Employee has his or her principal residence.
2. An Employee's Child, as defined herein, who is less than 26 years of age. **NOTE: Coverage of a Dependent Child will continue until the end of the calendar month he or she turns 26 years of age.**
3. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 45 days after the date the Child attains the limiting age as stated in the numbers above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

To establish a Dependent relationship, the Plan reserves the right to require documentation satisfactory to the Plan Administrator.

NOTE: Tax treatment for certain dependents. Federal tax law generally does not recognize former spouses, Legally Separated spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the spouse, partner, or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who may be covered under this Plan as eligible Dependents, as additional income to the Employee.

36. **"Diagnosis"**

"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of an Illness or Injury through evaluation of patient history, examination, and review of laboratory data. Diagnosis shall also mean the findings resulting from such act or process.

37. **"Diagnostic Service"**

"Diagnostic Service" shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of an Illness or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

38. **"Drug"**

"Drug" shall mean a Food and Drug Administration (FDA) approved Drug or medicine that is listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

39. **"Durable Medical Equipment"**

"Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which meets all of the following requirements:

1. Can withstand repeated use.
 2. Is primarily and customarily used to serve a medical purpose.
 3. Generally is not useful to a person in the absence of an Illness or Injury.
 4. Is appropriate for use in the home.
40. **"Elected Official"**
Elected Official means a person that is elected to serve Montgomery County, Texas and that by virtue of their office is entitled to participate and meet the requirements under the "Eligibility for Coverage" section for Elected Official participation.
41. **"Emergency"**
"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.
42. **"Emergency Medical Condition"**
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.
43. **"Emergency Services"**
"Emergency Services" shall mean, with respect to the treatment of an Emergency Medical Condition as follows:
1. An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
 2. Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).
- When furnished with respect to an Emergency Medical Condition, Emergency Services shall also include an item or service provided by a Non-Network Provider or Non-Participating Health Care Facility (regardless of the department of the Hospital in which items or services are furnished) after the Participant is stabilized and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the visit in which the Emergency Services are furnished, until such time as the Provider determines that the Participant is able to travel using non-medical transportation or non-emergency medical transportation, and the Participant is in a condition to, and in fact does, give informed consent to the Provider to be treated as a Non-Network Provider.
44. **"Employee"**
"Employee" means all full-time persons that meet the requirements under the "Eligibility for Coverage" section for Employee participation. "Employee" includes full-time "seasonal" employees, provided they meet the requirements under the "Eligibility for Coverage" section during their time of employment.

45. **"Employer"**
"Employer" is Montgomery County.
46. **"Essential Health Benefits"**
"Essential Health Benefits" typically mean, as described under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
47. **"Exclusion"**
"Exclusion" shall mean conditions or services that this Plan does not cover.
48. **"Experimental" and/or "Investigational"**
"Experimental" and/or "Investigational" ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:
1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
 2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:
 - a. Maximum tolerated dose.
 - b. Toxicity.
 - c. Safety.
 - d. Efficacy.
 - e. Efficacy as compared with the standard means of treatment or Diagnosis.
3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:
 - a. Maximum tolerated dose.
 - b. Toxicity.
 - c. Safety.
 - d. Efficacy.
 - e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

1. Only published reports and articles in the authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

49. **"Family Unit"**
"Family Unit" shall mean the Employee and his or her Dependents covered under the Plan.
50. **"FDA"**
"FDA" shall mean Food and Drug Administration.
51. **"FMLA"**
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.
52. **"FMLA Leave"**
"FMLA Leave" shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the County is required to extend to an eligible Employee under the provisions of the FMLA.
53. **"GINA"**
"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.
54. **"Habilitation/Habilitative Services"**
"Habilitation/Habilitative Services" shall mean health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.
55. **"HIPAA"**
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.
56. **"Home Health Care"**
"Home Health Care" shall mean the continual care and treatment of an individual if all of the requirements are met:
1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided.
 2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician.
 3. The Home Health Care is the result of an Illness or Injury.
57. **"Home Health Care Agency"**
"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which meets one of the following requirements:
1. Is a Federally certified Home Health Care Agency and approved as such under Medicare.
 2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required.
 3. Meets all of the following requirements.
 - a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home.
 - b. It has a full-time administrator.
 - c. It maintains written records of services provided to the patient.
 - d. Its staff includes at least one Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available.
 - e. Its employees are bonded and it provides malpractice insurance.
58. **"Hospital"**

"Hospital" shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons, on an Inpatient basis, with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is established and supported in whole by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center".

59. **"Illness"**

"Illness" shall mean any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any workers' compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as an Illness.

60. **"Impregnation and Infertility Treatment"**

"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

61. **"Incurred"**

An Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

62. **"Independent Freestanding Emergency Department"**

"Independent Freestanding Emergency Department" means a health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides any Emergency Services.

63. **"Injury"**

"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

64. **"Inpatient"**

"Inpatient" shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

65. **"Institution"**

"Institution" shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, Residential Treatment Facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, or any other such facility that the Plan approves.

66. **"Intensive Care Unit"**

"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit".

67. **"Intensive Outpatient Services"**

"Intensive Outpatient Services" shall mean programs that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment/rehabilitation/counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatment".

68. **"Leave of Absence"**

"Leave of Absence" shall mean a period of time during which the Employee must be away from his or her primary job with the Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Employer, and as provided for in the Montgomery County Employee Policy Manual.

69. **"Legal Separation" or "Legally Separated"**

"Legal Separation" and/or "Legally Separated" shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

70. **"Mastectomy"**

"Mastectomy" shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

71. **"Maximum Allowable Charge"**

For outpatient dialysis services, the Plan does not use a preferred provider organization (PPO). The Maximum Allowable Charge for Outpatient Dialysis Services is the lesser of:

1. The provider's normal charge for the same or a similar service or supply; or
2. 125% of what Medicare would allow.

For all other services, the "Maximum Allowable Charge" shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act (see "No Surprises Act – Emergency Services and Surprises Bills" within the section "Summary of Benefits,") if no negotiated rate exists, the Maximum Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS") either multiplied by 125%, or multiplied by a percentage that the particular Provider and/or others in the area customarily accept from all payers.

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on one of the following:

- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS;
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained Providers of care; or
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained Providers of care in traditional settings.

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by Providers in

the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

72. "Medical Child Support Order"

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement, or mediated settlement agreement meeting the requirements of § 6.602 of the Texas Family Code pending court approval) issued by a court of competent jurisdiction that meets one of the following requirements:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law).
2. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

73. "Medical Record Review"

"Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

74. "Medically Necessary"

"Medically Necessary", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Illness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of an Illness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary".

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

- A. The Drug is approved by the Food and Drug Administration (FDA).
- B. The prescribed Drug use is supported by one of the following standard reference sources:
 1. Micromedex® DRUGDEX®.
 2. The American Hospital Formulary Service Drug Information.
 3. Medicare approved compendia.
 4. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition.
- C. The Drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

75. **"Medicare"**
"Medicare" shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by the Centers for Medicare and Medicaid Services (CMS) and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.
76. **"Mental or Nervous Disorder"**
"Mental or Nervous Disorder" shall mean any illness or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.
77. **"National Medical Support Notice" or "NMSN"**
"National Medical Support Notice" or "NMSN" shall mean a notice that contains all of the following information:
1. The name of an issuing State child support enforcement agency.
 2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment.
 3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s).
 4. Identity of an underlying child support order/medical support order.
78. **"Network" or "In-Network"**
"Network" or "In-Network" shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms the Network's Providers have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant's identification card.
79. **"No-Fault Auto Insurance"**
"No-Fault Auto Insurance" is the basic reparations provision of a law or automobile insurance policy providing for payments without determining fault in connection with automobile Accidents.
80. **"Non-Network" or "Out-of-Network"**
"Non-Network" or "Out-of-Network" shall mean the facilities, Providers and suppliers that do not have an agreement with a designated Network to provide care to Participants.
81. **"Nurse"**
"Nurse" shall mean an individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.
82. **"Open Enrollment Period"**
"Open Enrollment Period" shall mean the timeframe specified by the Plan Administrator for Plan Participants to enroll in the Plan. Open enrollment period typically begins in November and runs for a period of three weeks, but remains subject to Commissioners Court approval.
83. **"Other Plan"**
"Other Plan" shall include, but is not limited to:
1. Any primary payer besides the Plan.
 2. Any other group health plan.
 3. Any other coverage or policy covering the Participant.

4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
 5. Any policy of insurance from any insurance company or guarantor of a responsible party.
 6. Any policy of insurance from any insurance company or guarantor of a third party.
 7. Workers' compensation or other liability insurance company.
 8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.
84. **"Outpatient"**
"Outpatient" shall mean treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory, or x-ray facility, an Ambulatory Surgical Center, or the patient's home.
85. **"Partial Hospitalization"**
"Partial Hospitalization" shall mean medically directed intensive, or intermediate short-term mental health and Substance Abuse treatment, for a period of less than twenty-four (24) hours but more than four (4) hours in a day in a licensed or certified facility or program.
86. **"Participant"**
"Participant" shall mean any Employee, Dependent, individual that is covered under the Plan through COBRA continuation, or retiree who is eligible for benefits and enrolled under the Plan.
87. **"Participating Health Care Facility"**
"Participating Health Care Facility" shall mean a Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.
88. **"Patient Protection and Affordable Care Act (PPACA)"**
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").
89. **"Physician"**
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Physician's Assistant, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.
90. **"Plan Year"**
"Plan Year" shall mean a one calendar year period commencing on the Effective Date or any subsequent anniversary of the Effective Date of this Plan and continuing until the next succeeding anniversary.
91. **"Pre-Admission Tests"**
"Pre-Admission Tests" shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that all of the following requirements are met:
1. The Participant obtains a written order from the Physician.
 2. The tests are approved by both the Hospital and the Physician.
 3. The tests are performed on an Outpatient basis prior to Hospital admission.
 4. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

92. **"Pregnancy"**
"Pregnancy" shall mean a physical state whereby a woman presently bears a child or children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered an illness for the purpose of determining benefits under this Plan.
93. **"Preventive Care"**
"Preventive Care" is the care a Participant receives to prevent illnesses or Diseases. It also includes screening and counseling to prevent or for early detection of health problems.
94. **"Prior Plan"**
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.
95. **"Prior to Effective Date" or "After Termination Date"**
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan (unless continuation of benefits applies).
96. **"Privacy Standards"**
"Privacy Standards" shall mean the applicable standards for the privacy of individually identifiable health information, pursuant to HIPAA.
97. **"Provider"**
"Provider" shall mean an entity whose primary responsibility is related to the supply of medical or behavioral health care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.
98. **"Psychiatric Hospital"**
"Psychiatric Hospital" shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a "Psychiatric Hospital", the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a "Psychiatric Hospital".
- To be deemed a "Psychiatric Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.
99. **"Qualified Medical Child Support Order" or "QMCSO"**
"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan.
100. **"Qualifying Payment Amount" or "QPA"**
"Qualifying Payment Amount" means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third Party Administrator (if calculated by the Third Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

101. "Recognized Amount"

"Recognized Amount" shall mean, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

102. "Rehabilitation"

"Rehabilitation" shall mean treatment(s) designed to facilitate the process of recovery from Injury or Illness to as normal a condition as possible.

103. "Rehabilitation Hospital"

"Rehabilitation Hospital" shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Illness and/or Injury. To be deemed a "Rehabilitation Hospital", the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a "Rehabilitation Hospital", the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

104. "Residential Treatment Facility"

"Residential Treatment Facility" shall mean a facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

105. "Retiree"

"Retiree" shall mean any person meeting the definition of Retiree as defined by Montgomery County Commissioners Court and Chapter 175 of the Texas Local Government Code, in further accordance with the Plan provisions herein provided.

106. "Room and Board"

"Room and Board" shall mean a Hospital's charge for any of the following:

1. Room and complete linen service.
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation.
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education.
4. Other conditions of occupancy which are Medically Necessary.

107. "Security Standards"

"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic Protected Health Information (PHI), as amended.

108. "Skilled Nursing Facility"

"Skilled Nursing Facility" shall mean a facility that fully meets all of the following requirements:

1. It is licensed to provide professional nursing services on an Inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally disabled, Custodial Care, educational care or care of Mental or Nervous Disorders.
 7. It is approved and licensed by Medicare.
109. **"Specialty Drug(s)"**
"Specialty Drug(s)" shall mean high-cost prescription medications used to treat complex, chronic conditions including, but not limited to cancer, rheumatoid arthritis and multiple sclerosis. Specialty Drugs often require special handling (like refrigeration during shipping) and administration (such as injection or infusion). Please contact the Prescription Drug Plan Administrator to determine specific drug coverage.
110. **"State Elected Official"**
A "State Elected Official" is a District Judge, and District Attorney that has a District Office in the County Seat of Montgomery County, Texas.
111. **"Substance Abuse" and/or "Substance Use Disorder"**
"Substance Abuse" and/or "Substance Use Disorder" shall mean any disease or condition that is classified as a Substance Use Disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant State guideline or applicable sources.
- The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.
112. **"Substance Abuse Treatment Center"**
"Substance Abuse Treatment Center" shall mean an Institution whose facility is licensed, certified or approved as a Substance Abuse Treatment Center by a Federal, State, or other agency having legal authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Abuse. To be deemed a "Substance Abuse Treatment Center", the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established, and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the "Substance Abuse Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.
113. **"Surgery"**
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.
114. **"Surgical Procedure"**
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."
115. **"Survivor"**
Survivor means an eligible surviving Spouse and/or Dependent of an Employee as defined in Chapter 615 of the Local Government Code.
116. **"Third Party Administrator"**
"Third Party Administrator" shall mean the claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims. The Third Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.
117. **"Uniformed Services"**
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

118. "USERRA"

"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

119. "Utilization Review Manager"

"Utilization Review Manager" shall mean a team of medical care professionals selected to conduct pre-certification review, emergency admission review, continued stay review, discharge planning, patient consultation, and case management. For more information, see the Utilization Management section of this document.

120. "Waiting Period"

"Waiting Period" shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ELIGIBILITY FOR COVERAGE

1. Eligibility for Individual Coverage

Each Employee will become eligible for coverage under this Plan with respect to himself or herself on the first day of the month, following completion of a Waiting Period of 58 days from commencement of full-time employment provided the Employee has begun work for his or her Participating Employer.

Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Waiting Period of this Plan. The following requirements will additionally apply:

- A. **Employees:** All full-time regular Employees will be eligible, including their eligible dependents for Health Care Benefits under this Plan that fulfill the following participation requirements:
 - 1. Complete the plan enrollment application within their first forty-five (45) days of employment;
 - 2. Satisfy the waiting period;
 - 3. Are in a full-time budgeted position;
 - 4. Work a minimum of 30 hours per week or 130 hours per month for the Employer; and additionally,
 - 5. An Employee shall be deemed to be in full-time employment in accordance with Montgomery County Employee Policy Manual.
- B. **Elected Officials:** All Elected Officials that hold a County Office that satisfy the waiting period and are actively at work on their first day in their elected position, and their eligible dependents, are eligible when said Elected Officials:
 - 1. Complete the plan enrollment application within their first forty-five (45) days of employment; and
 - 2. Satisfy the waiting period.
- C. **Appointed Officials:** All Appointed Officials that hold a County Office that satisfy the waiting period and are actively at work their first day in their appointed position, and their eligible dependents, are eligible when said Appointed Officials:
 - 1. Complete the plan enrollment application within their first forty-five (45) days of employment; and
 - 2. Satisfy the waiting period.
- D. **State Elected Officials:** State District Judges and the District Attorney that have a District Office in the County Seat of Montgomery County, Texas and have State medical benefit coverage, offered by the State of Texas, may elect and participate in this medical plan. If the State coverage is elected by said Official, the State plan will be considered primary coverage and this medical plan will be considered Secondary coverage, and will provide benefits based on this plans schedule of benefits and will only pay for Eligible Expenses after the State plan has paid. Irrespective of the Plan having primary or secondary status, these State Elected Officials that satisfy the waiting period and are actively at work their first day in their elected position, and their eligible dependents, are eligible under this Plan when said State Elected Officials:
 - 1. Complete the plan enrollment application within their first forty-five (45) days of employment; and
 - 2. Satisfy the waiting period.
- E. **Retirees:** All Retirees and their eligible dependents that meet the qualifications for retiree continuation of coverage and make application prior to the last day before retirement (see section below regarding retiree participation).
- F. **Seasonal Employees (Under the section titled "DEFINITIONS", see "Employee".):**
- G. All other persons are excluded.

2. Reinstatement of Coverage

A covered Employee who is terminated and rehired will be treated as a new Employee upon rehire only if the Employee was not credited with an hour of service with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire. If rehired within 13 weeks from termination, the Employee's coverage will be reinstated on the first of the month following rehire. If the Employee is rehired in the same month as the termination date, the Employee's coverage will be reinstated with no lapse in coverage.

3. Eligibility for Retiree Coverage / Continuation of Coverage / Chapter 175 of the Local Government Code

- A. Montgomery County, Texas will offer continued health benefits subject to the provisions of Chapter 175 of the Local Government Code. A retiring Employee ("Retiree"), that meets the eligibility requirements, as defined by Montgomery County Commissioners Court and their currently covered eligible Dependents will be eligible for the then current benefits, but not greater benefits than the Retiree would receive during employment. The Retiree shall not be eligible for the health

- benefits if the Retiree is eligible for group health benefits through another employer. Upon the Retiree's death, Dependent medical benefits will cease, surviving Dependents will be eligible for COBRA up to thirty-six (36) months.
- B. Dependent eligibility is based on the retired Employee. If the Retired Employee does not choose Retiree coverage, Dependent coverage will not be available. If the Retiree elects Retiree coverage and also elects Dependent coverage, those eligible Dependents must be covered under the plan prior to the Employees' retirement, to be considered eligible.
 - C. The Retiree must satisfy the eligibility for retirement requirements under the Texas County and District Retirement System and any additional requirements, as adopted by Montgomery County Commissioners Court, to be eligible for this benefit.
 - D. When the Retiree or their eligible Dependent becomes eligible for Federal Medicare Benefits, Montgomery County, Texas may substitute this Plan for another plan as authorized by law.
 - E. Written notification will be given to the Montgomery County Risk Management Department on or before the last day of employment. Late notification will result in ineligibility. All other plan provisions and requirements will apply. Should the Retiree elect to discontinue coverage under this Plan, the Retiree and/or Dependent may not re-enroll. Should the Retiree elect to discontinue coverage on a Dependent, that Dependent will no longer be eligible for coverage and will not be eligible to reenroll in this plan. Retirees covered under this plan may only enroll Dependents that are covered under the plan at the time of retirement. No new Dependents will be eligible for coverage once the Retiree is receiving Retiree benefits.
 - F. The amount of contributions, if any, for this Health Benefits Plan by the Retiree, for coverage's selected by the Retiree, will be adjusted, as necessary, by Montgomery County Commissioners Court.
 - G. Full payments of the required contributions are due monthly, payable on the first (1st) day of the month. Any payments not received by the tenth (10th) day of the month in which due may result in termination of benefits. No partial payments are accepted and no reinstatement in this Health Benefit Plan will be allowed.
 - H. Retiree benefits under this Employee Benefits Plan will be coordinated with Medicare and it will be assumed that the Retiree or eligible Dependent has chosen Medicare and all its options once they become entitled to Medicare whether due to age or disability. Benefits from this plan will pay as if the Retiree or eligible dependent had enrolled in Parts A & B of Medicare in the event that the Retiree does not choose to enroll in Parts A & B of Medicare.
 - I. Retirees that are married to a County Employee when they retire that have coverage under this plan, will be allowed to add to their coverage the remaining Spouse/Employee when the remaining Spouse/Employee leaves the employment of Montgomery County, Texas as long as there is no lapse in coverage and as long as the Spouse/Employee was covered under the plan for at least twenty-four (24) continuous months prior to separation of employment with Montgomery County, Texas.
 - J. Montgomery County, Texas offers County Paid / Subsidized Health Benefits for Employees hired prior to January 1, 2021 that can meet additional requirements at the time of retirement, and offers unsubsidized health benefits for Employees hired on or after January 1, 2021, that can meet certain requirements at the time of retirement. Please call the County Risk Management Department for a complete copy of applicable qualifications, determined with respect to the date of hire:
 - 1. For employees hired on or after January 1, 2000 through February 24, 2008, please see "Extension of Benefits to Retirees of Montgomery County" as approved by Commissioners Court on October 18, 1999.
 - 2. For Employees hired on or after February 25, 2008 through September 30, 2009, please see "Clarification and Restatement of Montgomery County, Texas Qualifications for County Paid / Subsidized Retiree Health Benefits", as approved by Commissioners Court on February 25, 2008.
 - 3. For Employees hired on or after October 1, 2009 through December 31, 2020, please see "Clarification and Restatement of Montgomery County, Texas Qualifications for County Paid / Subsidized Retiree Health Benefits Effective for Employees hired On or After October 1, 2009", as approved by Commissioners Court on December 21, 2009.
 - 4. For Employees hired on or after January 1, 2021, please see "Clarification and Restatement of Montgomery County, Texas Qualifications for Retiree Health Benefits, Effective for Employees hired On or After January 1, 2021" as approved in Commissioners Court on December 15, 2020.

The aforementioned Qualifications remain subject to all other requirements under this section, hereinabove, and other applicable Plan provisions, unless specified otherwise by Commissioners Court. Montgomery County, Texas reserves the right, at any time to change, delete or add to any benefit or policies which have previously been adopted by Montgomery County Commissioners Court.

4. **Eligibility Dates for Dependent Coverage**

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan.
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan.
3. The first date upon which he or she acquires a Dependent.
4. If applicable, for a Dependent, the first of the month following the date the Dependent becomes eligible due to a qualifying status change event and appropriate documentation is received, as outlined in the Section 125 plan.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

In order for an Employee's Dependent to be covered under the Plan the Employee must be enrolled for coverage under the Plan. **Exception:** Survivor(s) that qualify under Government Code 615.073 are eligible to continue medical coverage under this Plan at the time of the Employee's death if the Survivor was already enrolled. A Survivor not enrolled at the time of the Employee's death will not be eligible to enroll.

Required Documentation for Proof of Dependent Status

- a. **Spouse:** Certified Marriage License or Certified Informal Marriage Certificate, and Social Security Number or Tax Identification Number.
- b. **Natural Child:** Certified Birth Certificate which shows name of legal parent (legal parent must be an Employee), Certified Divorce Decree, certified court order signed by a Judge or order for support by the Attorney General for the State of Texas stating responsibility for Dependent medical coverage and Social Security Number or Tax Identification Number.
- c. **Step-child:** Certified Birth Certificate which shows name of legal parent (legal parent must be an Employee or Spouse of the Employee), Certified Divorce Decree, certified court order signed by a Judge or order for support by the Attorney General for the State of Texas stating responsibility for Dependent medical coverage and Social Security Number or Tax Identification Number.
- d. **Adopted Children:** Certified copy of a legal certificate of Adoption Decree or other documentation evidencing placement of child with adoptive parent(s) with an anticipation of adoption, acceptable to Plan Sponsor (adoptive parent must be an Employee) and Social Security Number or Tax Identification Number.
- e. **Legal guardian/Ward:** Certified copy of legal guardianship decree (legal guardian must be an Employee) and Social Security Number or Tax Identification Number. The legal guardian's ward will be an "Eligible Dependent", as defined, only so long as the legal guardianship is in effect. Eligibility will cease if/when the guardianship ends according to the terms of the decree or is terminated by other legal proceedings.

Other/alternate legal documentation or (non-certified) copies of the above may be accepted by the Plan Sponsor as proof of Dependent status in Plan Sponsor's sole determination.

5. Effective Dates of Coverage: Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

- A. **Enrollment Application (paper or electronic as applicable).** Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form (either paper or electronic as applicable) furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within 45 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the subsequent date such Employee or Dependents are eligible.
- B. **Coverage as Both Employee and Dependent.** An eligible Participant may enroll in this Plan either as an Employee or as a Dependent, but not both.
- C. **Birth of Dependent Child.** Except as provided in "Newly Acquired Dependents," below, a newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth **only if application to add the Child is received by the Plan Administrator within 45 days following the Child's date of birth.** If such written application to add a newborn Child is received by the Plan Administrator AFTER the 45 day period immediately following the Child's date of birth, the Child is not eligible for the Plan until the next Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

- D. **Newly Acquired Dependents.** If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if the existing coverage extends to Dependents and written application is made within 45 days. If coverage for Dependents has not already been secured by the Employee, an application must be made to the Plan within 45 days of the date of the newly acquired Dependent's initial eligibility, and any required contributions must be made if enrollment is otherwise approved by the Plan Administrator.

For additional requirements, see "New Dependent" below.

- E. **Requirement for Employee Coverage.** Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage for themselves.
- F. **Dependents of Multiple Employees.** If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.
- G. **Medicaid Coverage.** An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.
- H. **FMLA Leave.** Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: It is the responsibility of the enrolled Employee to notify his or her Employer of any changes in the Dependent's status.

6. **Special and Open Enrollment**

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period.

A. **Loss of Other Coverage**

This Plan will permit an eligible Employee or Dependent (including his or her spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions is met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered.
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage.
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
 - a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted.
 - b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked).
 - c. The eligible Employee or Dependent moved out of a Health Maintenance Organization (HMO) service area with no other option available.
 - d. The Plan is no longer offering benefits to a class of similarly situated individuals.
 - e. The benefit package option is no longer being offered and no substitute is available.
 - f. The employer contributions under the other coverage were terminated.

If an Employee is currently enrolled in a benefit package, the Employee may elect to enroll in another benefit package under the Plan if the following requirements are met:

1. Multiple benefit packages are available.
2. A Dependent of the enrolled Employee has a special enrollment right or a qualifying status change event (as outlined in the Section 125 plan) in the Plan because the Dependent has lost eligibility for other coverage.

Special enrollment rights will not be available to an Employee or Dependent if either of the following requirements is met:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage; or

2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request for enrollment (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan and the request is made within 45 days from loss of coverage.

B. *New Dependent*

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, legal guardianship, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing or electronically, as applicable, no later than 45 days after he or she acquires the new Dependent. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if both of the following conditions are met:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period.
2. An individual has become a Dependent of the eligible Employee through marriage, legal guardianship, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M. for the following events:

1. In the case of marriage, on the date of the marriage.
2. For a legal guardianship, on the date on which such Child is placed in the covered Employee's home pursuant to a court order appointing the covered Employee as legal guardian for the Child.
3. In the case of a Dependent's birth, as of the date of birth.
4. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

C. *Additional Special Enrollment Rights*

Employees and Dependents who are eligible but not enrolled are entitled to enroll under one of the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination.
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined. For more information, visit <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

If the conditions for special enrollment are satisfied, coverage for the Employee and/or his or her Dependent(s) will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written or electronic request, as applicable, (including the Participant's enrollment application, either paper or electronic as applicable, in the case of enrollment) is received by the Plan.

D. *Open Enrollment*

Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Employees who are enrolled will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year. A Participant who fails to make an election during the Open Enrollment Period will have his or her enrollment automatically reduced to employee only

coverage on the High Deductible plan without retaining any options. Coverage for Participants enrolling during an Open Enrollment Period will become effective on January 1, as long as all other eligibility requirements have been met. If the other eligibility requirements have not been met, coverage for Participants enrolling during an Open Enrollment Period will become effective as stated in the provision, "Eligibility for Individual Coverage".

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

"Open Enrollment Period" shall mean the time frame specified by the Plan Administrator.

7. Relation to Section 125 Cafeteria Plan

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

8. Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child or Children of a Participant, not including an ex-stepchild or ex-stepchildren unless ordered otherwise by Court, who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child or Children reside with the Participant, provided the Child or Children are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child or Children shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

To be considered a Qualified Medical Child Support Order, the Medical Child Support Order must contain the following information:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order.
2. A reasonable description of the type of coverage to be provided by this Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
3. The period of coverage to which the order applies.
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if all of the following requirements are met:

1. It contains the information set forth in the Definitions section in the definition of "National Medical Support Notice."
2. It identifies either the specific type of coverage or all available group health coverage. If the Employer receives a NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated.
3. It informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the Child will be enrolled under the Plan's default option (if any).
4. It specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

A NMSN need not be recognized as a QMCSO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, except to the extent necessary to meet the requirements of a State law relating to Medical Child Support Orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible, perform the following:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO.
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall perform the following:

1. Notify the State agency issuing the notice with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
 - a. Whether the Child is covered under the Plan.
 - b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a State or political subdivision to effectuate the coverage.
2. Provide to the custodial parent (or any State official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

As required by Federal law, the Plan Administrator shall perform the following:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders.
2. Administer the provision of benefits under such qualified orders. Such procedures shall:
 - a. Be in writing.
 - b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order.
 - c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

A Participant of this Plan may obtain, without charge, a copy of the procedures governing QMCSO determinations from the Plan Administrator.

9. **Genetic Information Nondiscrimination Act ("GINA")**

"GINA" prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about any of the following:

- A. Such individual's genetic tests.
- B. The genetic tests of family members of such individual.
- C. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying pre-existing condition limitations. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

TERMINATION OF COVERAGE

Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. The last day of the month in, or with respect to which, he or she requests that such coverage be terminated, on the condition that such request is made on or before such date, unless prohibited by law (i.e., when election changes cannot be made due to Internal Revenue Code Section 125 "change in status" guidelines). *NOTE: The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.*
3. The last day of the month for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The last day of the month in which the Employee is no longer eligible for such coverage under the Plan.
5. The last day of the month in which the termination of employment occurs.
6. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

Termination Dates of Retiree Coverage

The coverage of any retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date of termination of the Plan.
2. The date of death of the covered retiree.
3. The date of the expiration of the last period for which the retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
4. The date the covered retiree becomes eligible for coverage under another Employer's health plan.

Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated.
2. Upon the discontinuance of coverage for Dependents under the Plan.
3. The date of termination of the Employee's coverage for himself or herself under the Plan.
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing.
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
 - a. Cessation of such disability or inability.
 - b. Failure to provide any required proof of continuous disability or inability or to submit to any required examination.
 - c. Upon the Child's no longer being dependent on the Employee for his or her support.
6. The day immediately preceding the date such person is no longer a Dependent, except for Dependent Children, as defined herein, except as may be provided for in other areas of this section.
7. The last day of the month in which such person ceases to be a Dependent Child, as defined herein, except as may be provided for in other areas of this section or within this document.
8. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan.
9. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent

gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

NOTE: *The Employer offers these benefits in conjunction with a cafeteria plan under Section 125 of the Internal Revenue Code and a voluntary termination must comply with the requirements of the Code and the cafeteria plan.*

CONTINUATION OF COVERAGE

Employer Continuation Coverage

Eligible Participants may seek to continue coverage upon the occurrence of any of the following:

- Leave of Absence (not meeting the definition of a FMLA Leave); coverage will continue for up to 6 months.

Leave of Absence means the Employee has obtained an approved leave of absence from the Employer as provided for in the Employer's rules, policies, procedures, and/or practices. This Plan will follow the Employer's rules, policies, procedures and or practices. An approved leave of absence will be no longer than six (6) continuous months. The length of time may be extended for County Law Enforcement Officials who are injured and hospitalized or incapacitated in the course of their official duties under the provisions of the Texas Constitution Article 3, Sec 52(e.) and as approved by the Elected or Appointed Official in charge of the injured Law Enforcement Official but not exceed the provisions of the Texas Constitution Article 3, Sec 52(e.) The above noted leave(s) run concurrently with FMLA, USERRA or any State-mandated family or medical leave, and/or any other applicable leaves of absence. If the Participant does not return from leave, at the end of the period listed above, the Participant's coverage will be deemed to have terminated for purposes of Continuation of Coverage under COBRA.

Continuation During Family and Medical Leave Act (FMLA) Leave

The Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits to the greater of the extent required by applicable law and Montgomery County Employee Policy Manual. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Continuation During USERRA

Participants who are absent from employment because they are in the Uniformed Services, and who are on active military duty, must be offered the right to continue health care benefits. If the military leave orders are for a period of 30 days or less, Participants cannot be required to pay more than the normal Participant contribution amount. After this period, Participants may elect to continue their coverage under this Plan for up to 24 months and Participants cannot be required to pay more than 102 percent of the full contribution amount during that time.

To continue coverage, Participants must comply with the terms of the Plan, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participant's family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, certain Participants and their eligible family members (called Qualified Beneficiaries) that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

To the extent the Plan does not fully or accurately reflect applicable COBRA regulations, the Plan will at all times comply with such regulations.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Participants can learn more about many of these options at www.healthcare.gov. Additionally, the Participant may qualify for a special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

Qualifying Events

A qualifying event is any of those listed below if the Plan provided that the Participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of COBRA continuation coverage. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced.
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Employee dies.
2. The Employee's hours of employment are reduced.
3. The Employee's employment ends for any reason other than his or her gross misconduct.
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both).
5. The Employee becomes divorced from his or her spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies.
2. The parent-covered Employee's hours of employment are reduced.
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct.
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both).
5. The parents become divorced.
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

Filing a proceeding in bankruptcy under title 11 of the United States Code may be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to Employer, and that bankruptcy results in the loss of coverage for any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary, with the bankruptcy being deemed to be the Qualifying Event. The retired Employee's Dependent(s) (if applicable) will also become Qualified Beneficiaries if the bankruptcy (Qualifying Event) results in a loss of their coverage under the Plan.

Employer Notice of Qualifying Events

When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the COBRA Administrator of the Qualifying Event.

Employee Notice of Qualifying Events

In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the COBRA Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are any of the following:

1. **Notice of Divorce or Separation:** Notice of the occurrence of a Qualifying Event that is a divorce of a covered Employee (or former Employee) from his or her spouse.
2. **Notice of Child's Loss of Dependent Status:** Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan.
3. **Notice of a Second Qualifying Event:** Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
4. **Notice Regarding Disability:** Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage.
5. **Notice Regarding End of Disability:** Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the COBRA Administrator. This form is available, without charge, from the COBRA Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this section for additional information.

Notification must be received by the COBRA Administrator. The COBRA Administrator is:

Boon-Chapman Benefit Administrators, Inc.
PO Box 9201
Austin, Texas 78766
Phone: 1-800-252-9653

A form of notice is available, free of charge, from the COBRA Administrator and must be used when providing the notice.

Deadline for Providing the Notice

For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs.
2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event.
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the COBRA Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. The date of the disability determination by the SSA.
2. The date on which a Qualifying Event occurs.
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event.

4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

For a change in disability status described above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled.
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the COBRA Administrator.

The notice must be postmarked (if mailed), or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA Continuation Coverage is lost, and if the person is electing COBRA Continuation Coverage, his or her coverage under the Plan will terminate on the last date for which he or she is eligible under the terms of the Plan, or if the person is extending COBRA Continuation Coverage, such Coverage will end on the last day of the initial 18-month COBRA coverage period.

Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required Contents of the Notice

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee.
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator.
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period).
4. A description of the Qualifying Event (for example, divorce, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status).
 - a. In the case of a Qualifying Event that is divorce, name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan, date of divorce, and a copy of the decree of divorce.
 - b. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
 - c. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age).
 - d. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child or Children covered under the Plan.
 - e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination.
 - f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination.
5. Identification of the Qualified Beneficiaries (by name or by status).
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage.
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected.
8. How to elect continuation coverage.

9. What will happen if continuation coverage isn't elected or is waived.
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events.
11. How continuation coverage might terminate early.
12. Premium payment requirements, including due dates and grace periods.
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries.
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD.
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or the SSA's determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified by the COBRA Administrator in the request, the COBRA Administrator may reject the notice if it does not contain enough information for the COBRA Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the COBRA Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60 day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

In the event that the COBRA Administrator determines that the individual is not entitled to COBRA Continuation Coverage, the COBRA Administrator will provide to the individual an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

Waiver Before the End of the Election Period

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Duration of COBRA Continuation Coverage

The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Dependent of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to thirty-six months after the date of Medicare entitlement, which is equal to twenty-eight months after the date of the Qualifying Event (thirty-six months minus eight months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA Continuation Coverage can be extended.

Disability Extension of COBRA Continuation Coverage

Disability can extend the 18 month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours, if an Employee or anyone in an Employee's family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled, and the Employee notifies the COBRA Administrator. The Employee and his or her Dependents may thereby be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18 month period of COBRA Continuation Coverage. The Plan can charge 150% of the premium cost for the extended period of coverage.

Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to the Plan Administrator or COBRA Administrator in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce, or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

Shorter Duration of COBRA Continuation Coverage

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of 18 months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage will terminate immediately, unless otherwise noted, upon the occurrence of any of the following events:

- Contributions are not paid in full on a timely basis,
- The Plan Sponsor ceases to maintain any group health plan,
- The Qualified Beneficiary begins coverage under another group health plan after electing continuation coverage,
- The Qualified Beneficiary enrolls in Medicare Part A or B after electing continuation coverage,
- The Qualified Beneficiary engages in fraud or other conduct that would justify termination of coverage of a similarly situated participant or beneficiary not receiving continuation coverage, or
- If covered under an 11-month disability extension, there is a final determination that the Qualified Beneficiary is no longer disabled for Social Security Purposes (coverage shall terminate on the first day of the month at least 30 days after the determination is made that the Qualified Beneficiary is no longer disabled).

If COBRA Continuation Coverage is terminated early, the Plan will provide the Qualified Beneficiary with an early termination notice.

Employee Notice of Other Enrollment

If the Qualified Beneficiary becomes enrolled in Medicare or under another group health plan after electing COBRA Continuation Coverage, the Qualified Beneficiary must notify the COBRA Administrator in writing immediately.

Contribution and/or Premium Requirements

The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator must allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

Trade Reform Act and Consolidated Appropriations Act, 2021

The Consolidated Appropriations Act, 2021 has extended certain provisions of the Trade Reform Act, which created a special COBRA right applicable to certain employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a Health Coverage Tax Credit (HCTC) or get advance payment of the applicable percentage of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

A Participant's eligibility for subsidies under the Consolidated Appropriations Act, 2021, affects his or her eligibility for subsidies that provide premium assistance for coverage purchased through the Health Insurance Marketplace. For each coverage month, a Participant must choose one or the other, and if he or she receives both during a tax year, the IRS will reconcile his or her eligibility for each subsidy through his or her individual tax return. Participants may wish to consult their individual tax advisors concerning the benefits of using one subsidy or the other.

Participants may contact the Plan Administrator for additional information or if they have any questions, they may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Reform Act is available at www.doleta.gov/tradeact; for information about the Health Coverage Tax Credit (HCTC), please see: <https://www.irs.gov/Credits-&-Deductions/Individuals/HCTC>.

Additional Information

Please contact the COBRA Administrator with any questions about the Plan and COBRA Continuation Coverage at the following:

Boon-Chapman Benefit Administrators, Inc.
PO Box 9201
Austin, Texas 78766
Phone: 1-800-252-9653
Fax: 1-512-459-1592
Website/Email: www.boonchapman.com

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about a Participant's rights under COBRA, HIPAA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit <https://www.dol.gov/agencies/ebsa>. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Current Addresses

Important information may be distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep the COBRA Administrator (who has been previously identified in this Continuation of Coverage section) informed of any changes in the addresses of family members.

GENERAL LIMITATIONS AND EXCLUSIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

1. **Administrative Costs.** That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.
2. **After the Termination Date.** That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.
3. **Broken Appointments.** That are charged solely due to the Participant's having failed to honor an appointment.
4. **Confined Persons.** That are for services, supplies, and/or treatment of any Participant that were Incurred while confined and/or arising from confinement in a prison, jail or other penal institution.
5. **Cosmetic Surgery.** That are Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage or pain resulting from an Accident or Medically Necessary treatment; (b) because of infection or illness; (c) because of congenital disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).
6. **Custodial Care.** That do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise.
7. **Excess.** That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.
8. **Experimental.** That are Experimental or Investigational.
9. **Family Member.** That are performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "in law."
10. **Foreign Travel.** That are received outside of the United States if travel is for the purpose of obtaining medical services, unless otherwise approved by the Plan Administrator. This exclusion does not include emergency medical services obtained outside the United States.
11. **Government.** That the Participant obtains, but which is paid, may be paid, is provided or could be provided at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.
12. **Government-Operated Facilities.** That meet the following requirements:
 1. That are services furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
 2. That are services or supplies which can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

NOTE: This Exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This Exclusion does not apply where otherwise prohibited by law.

13. **Hospital Acquired Conditions.** That are for medical treatment directly related to Hospital Acquired Conditions, as defined by CMS or in Network Provider Contracts. These also cannot be billed to the patient.
14. **Incurred by Other Persons.** That are expenses actually Incurred by other persons.
15. **Long Term Care.** Long-term care is a range of services and support for your personal care needs. Instead, long-term care typically provides assistance with basic personal tasks of everyday life, sometimes called "activities of daily living." This includes things like dressing, bathing and using the bathroom. Long-term care may also include home-delivered meals, adult day health care, and other services. Long-term care can be provided at home, in the community, in an assisted living facility, or in a nursing home.
16. **Medical Necessity.** That are not Medically Necessary as defined herein.
17. **Membership Programs.** For enrollment and/or participation in a health, athletic, or similar club or program.
18. **Military Service.** That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.
19. **Negligence.** That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator. This includes payments for medical treatment related to Hospital Acquired Conditions or Never Events as defined by CMS. These are not billable to the patient.
20. **No Coverage.** That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.
21. **No Legal Obligation.** That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.
22. **Non-Prescription Drugs.** For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available.
23. **Not Acceptable.** That are not accepted as approved practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).
24. **Not Covered Provider.** That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.
25. **Not Specified As Covered.** That are not specified as covered under any provision of this Plan.
26. **Occupational.** That are for any condition, illness, injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit, typically covered under Workers Compensation laws.
27. **Other than Attending Physician.** That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Illness and performed by an appropriate Provider.
28. **Postage, Shipping, Handling Charges, Etc.** That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

29. **Prior to Coverage.** That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.
30. **Professional (and Semi-Professional) Athletics (Injury/Illness).** That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.
31. **Prohibited by Law.** That are to the extent that payment under this Plan is prohibited by law.
32. **Provider Error.** That are required as a result of unreasonable Provider error, also known as Never Events. The National Quality Forum (NQF) defines a Never Event as errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. For purposes of this policy, the following events have been determined to be Never Events:
- Surgery or other invasive procedure performed on the wrong patient
 - Surgery or other invasive procedure performed on wrong site
 - Wrong surgical or other invasive procedure performed on a patient
- If the surgical or invasive procedure is not consistent with the documented informed consent of the member then we consider it a Never Event. The provider is not allowed to bill for services prohibited by the network provider contract.
33. **Riot.** That are Incurred as a result of voluntary participation in a riot. This Exclusion does not apply to an innocent bystander of a riot.
34. **Self-Care/Self-Help.** For recreational or educational therapy, vocational therapy or non-medical self-care or self-help training.
35. **Self-Inflicted.** That are Incurred due to an intentionally self-inflicted Injuries or Illness not (a) resulting from being the victim of an act of domestic violence or (b) resulting from a documented medical condition (including both physical and mental health conditions).
36. **Subrogation, Reimbursement, and/or Third Party Responsibility.** That are for an Illness or Injury not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.
37. **War.** That are Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is an active duty member of the armed forces of any country, or during service by a Participant in the armed forces of any country, wherein military coverage is required to be the sole coverage. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any illness or injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the illness or injury if the illness or injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

PLAN ADMINISTRATION

Plan Sponsor

The Plan Sponsor reserves the unilateral right and discretion to make any changes, without advance notice, to the Plan which deems to be necessary or appropriate, in its discretion, to comply with applicable law, regulation or other authority issued by a governmental entity. The Plan Sponsor also reserves the unilateral right and discretion to amend, modify, or terminate, without advance notice, all or any part of the Plan and to make any other changes that it deems necessary or appropriate in its discretion. Changes in the Plan may occur in any or all parts of the Plan, including, but not limited to, benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like, under the Plan.

Plan Administrator

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services in accordance with the Plan and applicable laws. The claims processing and other technical services delegated to the Third Party Administrator notwithstanding, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

The Plan is administered by the Plan Administrator in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, including correction of any error or defect, supplying any omission, reconciling any inconsistency, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties, subject only to the claims appeal provisions and procedures of the Plan. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to comply with applicable laws, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal provisions and procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits.

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To appoint and supervise a Third Party Administrator to pay claims.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
10. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Any amendment to the Plan that is not made effective at the beginning of a normal Plan Year by integration into a full Plan Document restatement, including suspension and/or termination, shall follow the amendment procedure outlined in this section. The amendment procedure is accomplished by a separate, written amendment decided upon and/or enacted by resolution of the Plan Sponsor's Commissioners Court in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. As it relates to distribution of assets upon termination of the Plan, any contributions paid by Participants will be used for the exclusive purpose of providing benefits and defraying reasonable expenses related to Plan administration, and allocated to any replacing coverage(s) to the extent allowed by law, as directed by the Plan Sponsor.

COST CONTAINMENT INCENTIVES

As and when Commissioners Court approves, the Plan Sponsor will implement provisions and model benefit coverage and availability such that Participants will enjoy substantial savings and benefits when they take proactive measures to contain overall Plan expenditures. The following provisions may also appear elsewhere in this document, and address the various instances where responsible, cost-containment behavior is incentivized.

Employer Cost Containment Incentives

Claim Audit Review Program

The Claim Audit Review Program is designed to reward Employees with a percentage of savings for identifying erroneous charges on bills recoverable by the Plan.

Refer to this section under the "CLAIM PROCEDURES; PAYMENT OF CLAIMS" for additional details.

CLAIM PROCEDURES; PAYMENT OF CLAIMS

1. Introduction

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim.

The availability of health benefit payments is dependent upon Claimants complying with the following:

2. Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan and applicable law. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third Party Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an assignment of benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

A call from a Provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and Exclusions. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Claimant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered. The Plan Administrator may revoke an assignment of benefits previously issued to a Provider at its discretion and treat the Participant as the sole beneficiary.

There are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, because of this Plan's design Pre-service Urgent claims will not be filed with the Plan; Post-service claims will instead be filed after the urgent care is provided.

- A. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim".

Urgent or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Claim". In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

- B. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.
- C. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 calendar days of the date charges for the service(s) and/or supplies were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent claim that also is a Pre-service claim) is considered to be filed when the request for approval of treatment or services is received by the Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with the industry standard claim form:

1. The date of service.
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies.
3. The place where the services were rendered.
4. The Diagnosis and procedure codes.
5. Any applicable pre-negotiated rate.
6. The name of the Plan.
7. The name of the covered Employee.
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of urgent care claims) from receipt by the Claimant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service claims and Concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims:

- a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
 - b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).
2. Concurrent Claims:
 - a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination.
 - b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided as soon as possible.
 - c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).
3. Post-service Claims:
 - a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
 - b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
 - c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.
4. Extensions:
 - a. Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
 - b. Post service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30 day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of Pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
2. Specific reason(s) for a denial.

3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to the procedures.
5. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
6. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, upon request).
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, upon request.
9. In a claim involving urgent care, a description of the Plan's expedited review process.

3. Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. More specifically, the Plan provides:

1. A 180-day timeframe following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination. The Plan will not accept appeals filed after a 180 day timeframe.
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
3. A review that does not afford deference to the previous Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
4. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination.
5. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan Administrator may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.
6. Upon request, the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice.
7. If applicable, a discussion of the basis for disagreeing with the disability determination made by either (a) the Social Security Administration; or (b) an independent medical expert that has conducted a full medical review of the Claimant if presented by the Claimant in support of the claim.
8. That a Claimant will be provided, upon request: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits in possession of the Plan Administrator or the Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and (d) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

Requirements for First Level Appeal

The Claimant must file the appeal in writing (although oral appeals are permitted for Pre-service urgent care claims) within 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service Claims. All Pre-service claims must be sent to the Utilization Review Manager. Oral appeals should be submitted in writing as soon as possible after it has been initiated. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Prime Dx
PO Box 9201
Austin, Texas 78766
Phone: 1-800-477-4625
Fax: 1-800-213-5108

For Post-service Claims. To file any appeal in writing, the Claimant's appeal must be addressed as follows:

Boon-Chapman Benefit Administrators, Inc.
PO Box 9201
Austin, Texas 78766
Phone: 1-800-252-9653
Fax: 1-512-459-1592
Website/Email: www.boonchapman.com

It shall be the responsibility of the Claimant or authorized representative to submit an appeal under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant.
2. The Employee/Claimant's social security number.
3. The group name or identification number.
4. All facts and theories supporting the claim for benefits.
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
2. Concurrent Claims: The response will be made within a reasonable period of time as following the time period described under "Timing of Claim Decisions" above but not later than 30 days after determination is made.
3. Post-service Claims: Within a reasonable period of time, but not later than 30 days per internal appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. Specific reason(s) for a denial.
3. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice.
4. A statement that the Claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits.
5. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided.
6. A description of the Plan's review procedures and the time limits applicable to the procedures.

7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, upon request.
8. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Participants with the internal claims and appeals processes.

Furnishing Documents in the Event of an Adverse Determination

In the case of an Adverse Benefit Determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the provision relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final

The decision by the Plan Administrator or other appropriate named designee of the Plan Administrator on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Requirements for Second Level Appeal

The Claimant must file an appeal regarding a Pre-service or Post-service claim and applicable Adverse Benefit Determination, in writing within 60 days following receipt of the notice of the first level Adverse Benefit Determination.

Two Levels of Appeal

This Plan requires two levels of appeal (Pre-service or Post-service) by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the above-outlined submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the final Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with applicable law, applies only to an Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act and under 45 C.F.R. 147.136.

4. Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an assignment of benefits, requiring a release of information, or requesting completion a similar form. An assignment of benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

5. Autopsy

Upon receipt of a claim for a deceased Claimant for any condition illness or injury that is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

6. Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an assignment of benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an assignment of benefits occurred.

Assignments

For this purpose, the term "Assignment of Benefits" (or "AOB") is defined as an arrangement whereby a Participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less Deductible, Copayments and Coinsurance amounts, to a medical Provider. If a Provider accepts said arrangement, the Provider's rights to receive Plan benefits are equal to those of the Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an AOB and Deductibles, Copayments, and Coinsurance amounts, as consideration in full for treatment rendered.

The Plan Administrator may revoke an AOB at its discretion and treat the Participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this Plan may be assigned by a Participant to the Provider as consideration in full for services rendered; however, if those benefits are paid directly to the Participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant, has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries. A medical Provider which accepts an AOB does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan Exclusions, limitations, maximums and other provisions. Assignment of benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If assignment of benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider must satisfy

all applicable credentialing and licensing requirements in the sole determination of Plan Administrator; and claims for benefits must be submitted to the Plan in English.

Recovery of Payments

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or Exclusions, or should otherwise not have been paid by the Plan. As such, this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Claimant or Dependent on whose behalf such payment was made.

A Claimant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or divided amount. When a Claimant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

In the event an error involves a non-payment or insufficient deduction of premiums from a Participant employee's pay when otherwise required under applicable Plan enrollment elections, such deficiency shall remain a monetary obligation owed by the Participant employee to the Plan Sponsor until fulfilled. Accordingly, the Plan Administrator reserves the right to take all appropriate steps for reimbursement of such funds to the Plan Sponsor to the fullest extent allowed by law, and Participant employee shall be further obligated to cooperate with the Plan Administrator to achieve the same.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan in accordance with applicable laws. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, in accordance with applicable law.

Further, Claimant and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Claimant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made for any of the following circumstances:

1. In error.
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act.
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences.
4. With respect to an ineligible person.

5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions.
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Claimant for any outstanding amount(s).

Medicaid Coverage

A Claimant's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Claimant. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Claimant, as required by the State Medicaid program; and the Plan will honor any Subrogation rights the State may have with respect to benefits which are payable under the Plan.

Limitation of Action

A Claimant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within two years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

7. Claim Audit Review Program

The Claim Audit Review Program is designed to reward Employees for identifying and recovering erroneous charges on bills for medical services and supplies furnished to Participants.

1. When a Claimant independently identifies eligible overpayments for services, supplies and treatments not rendered or received the Claimant will be awarded 50% of the recovered amount up to a \$1,000 maximum on claims the Claimant reports to the Plan Administrator that are successfully recovered by the Plan.
2. The Plan Administrator will assist the Claimant with the determination of an eligible overpayment and will pursue the collection of the overpayment amount.
3. A final determination letter will be sent to the Claimant after the status of the audit has been completed. The Plan Administrator shall make the final determination regarding all qualifications for eligible overpayment and awarded amounts.

Submittal Procedures

Information regarding an overpayment or potential overpayment must be submitted for Claims Audit Review within 15 days of identification. All considerations for eligible overpayment must be submitted in writing and accompanied by supporting documentation as listed below:

- Claim number or copy of the Explanation of Benefits;
- Any correspondence with the Provider; and
- A statement that includes the reason for belief of an eligible overpayment.

Payment of Awards for Claim Audit Recoveries

Awards shall only apply to the first occurrence of each claim submitted for Claim Audit Review in accordance with then current County procedures. Awards will be made following the final determination and subsequent recovery of the overpayment.

Employees shall only be eligible for award under the Claim Audit Review Program if eligible overpayments, actual or potential, are the result of services, supplies or treatments billed but not rendered or received.

COORDINATION OF BENEFITS

1. **Coordination of the Benefit Plans**

Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Participant is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

2. **Standard Coordination of Benefits**

The plan that pays first according to the rules will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to each one's plan formula minus the amount the primary plan paid.

3. **Benefits Subject to This Provision**

The following only applies to the medical benefits of the Plan.

4. **Excess Insurance**

If at the time of Injury, Illness or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits shall be excess to any of the following:

- A. The responsible party, its insurer, or any other source on behalf of that party.
- B. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state.
- C. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
- D. Workers' compensation or other liability insurance company.
- E. Any other source of coverage, including, but not limited to, the following:
 - Crime victim restitution funds
 - Civil restitution funds
 - No-fault restitution funds such as vaccine injury compensation funds
 - Any medical, applicable disability or other benefit payments
 - School insurance coverage

5. **Vehicle Limitation**

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies and will exclude benefits subject to the Exclusions in this Plan up to the maximum amount available to the Participant under applicable state law, regardless of a Participant's election of lesser coverage amount. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

6. **Effect on Benefits**

Application to Benefit Determinations

The plan that pays first according to the rules in the provision entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to each one's plan formula minus the amount the primary plan paid. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered secondary regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier regarding priority of payment.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when all of the following occur:

- A. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined.
- B. The rules in the provision entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the provision entitled "Application to Benefit Determinations", the rules establishing the order of benefit determination are:

- A. The benefits of a plan which covers the person on whose expenses a claim is based other than as a dependent shall be determined before the benefits of a plan which covers such person as a Dependent.
- B. If the person for whom claim is made is a dependent child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - 1. When the parents were never married, are separated, or are divorced, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - 2. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above, if there is a court decree, or mediated settlement agreement pursuant to the Texas Family Code, which would otherwise establish financial responsibility for the child's health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the child as a dependent child.

- C. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses a claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time.
- D. Notwithstanding anything to the contrary in this Plan document, to the extent required by Federal and State regulations, this Plan will pay before any Medicare, Tricare, Medicaid, State child health benefits or other applicable State health benefits program.

7. **Right to Receive and Release Necessary Information**

The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine, implement and apply the terms of this provision or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information and HIPAA releases as requested and as may be necessary to implement this provision.

8. **Facility of Payment**

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

9. **Right of Recovery**

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Coordination of Benefits section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or

organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

MEDICARE

Applicable to Active Employees and Their Spouses Ages 65 and Over

An Active Employee and his or her spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the section entitled "Coordination of Benefits"). If the Provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare approved expenses.

Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is enrolled in Medicare coverage because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of the Participant's Medicare entitlement, regardless of the date of enrollment, unless applicable Federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

1. Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to crime victim restitution funds, civil restitution funds, no-fault restitution funds (including vaccine injury compensation funds), uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party, any medical, applicable disability, or other benefit payments, and school insurance coverage (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain, to the full extent required by law of the Plan's conditional payment of benefits or payments from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan's rights to recovery shall be in compliance with, and to the maximum extent allowed by, all applicable laws, and equity. Accordingly the Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, where unallocated settlement funds are meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

2. Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Participant(s) receives or becomes entitled to receive benefits or when the Plan receives notice of an Injury claim, it shall be entitled to assert a priority subrogation lien to the extent it has become or may become obligated to provide Injury-related benefits. Notice of the Plan's right of subrogation, or of the priority lien that it claims, is sufficient to establish its subrogation rights with respect to insurers, third parties, attorneys, and other persons or entities against whom a Participant may have a right of recovery arising out of the injury. The Plan is not required to intervene in a personal Injury or other action brought by a Participant in order to establish or maintain the Plan's subrogation rights. The Plan is authorized, but not required, to initiate legal action in its name or in the name of the Participant in order to enforce the Plan's subrogation rights. Further, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the maximum extent allowed by law of such conditional payment by the Plan and reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold

any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan, to the full extent allowed by law.

Whether or not the Participant(s) fails to file a claim or pursue damages against:

- A. The responsible party, its insurer, or any other source on behalf of that party;
- B. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- C. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy;
- D. Workers' compensation or other liability insurance company; and/or
- E. Any other source of Coverage, including, but not limited to, the following:
 - Crime victim restitution funds
 - Civil restitution funds
 - No-fault restitution funds such as vaccine injury compensation funds
 - Any medical, applicable disability or other benefit payments
 - School insurance coverage

the Participant(s) authorizes the Plan, at Plan's sole option, to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

3. **Right of Reimbursement**

The Plan shall be entitled to recover, to the full extent allowed by law, benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall further be entitled to any and all expenses, costs and fees incurred by the Plan to secure such recovery. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation, otherwise and to the extent allowable by law, may be deducted from the Plan's recovery without the prior, express written consent of the Plan. Additionally, the Participant shall indemnify, to the full extent allowed by law, the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent.

Except to the extent otherwise allowed by law, the Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness, injury or disability, to the full extent allowed by law.

4. **Participant is a Trustee Over Plan Assets**

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

- A. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
- B. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
- C. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
- D. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

5. **Release of Liability**

The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

6. **Excess Insurance**

If at the time of Injury, Illness or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

- A. The responsible party, its insurer, or any other source on behalf of that party.
- B. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
- C. Any policy of insurance from any insurance company or guarantor of a third party, including but not limited to an employer's policy.
- D. Workers' compensation or other liability insurance company.
- E. Any other source of Coverage, including, but not limited to, the following:
 - Crime victim restitution funds
 - Civil restitution funds
 - No-fault restitution funds such as vaccine injury compensation funds
 - Any medical, applicable disability or other benefit payments

- School insurance coverage

7. **Separation of Funds**

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien shall, to the extent allowed by law, exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, and/or the Plan's right to subrogation and reimbursement.

8. **Wrongful Death**

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply to the full extent allowed by law, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

9. **Obligations**

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
- To provide the Plan with pertinent information regarding the Illness, disability, or Injury, including accident reports, settlement information and any other requested additional information.
- To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
- To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
- To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
- To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
- To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
- To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
- To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
- In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
- To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all reimbursable benefits paid, or to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

10. **Offset**

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan; said amount remains a liability to the County until deemed fulfilled per the Plan Administrator. This provision applies even if the Participant has disbursed settlement funds.

11. **Minor Status**

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

12. **Language Interpretation**

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

13. **Severability**

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

MISCELLANEOUS PROVISIONS

1. **Clerical Error/Delay**

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Excess contributions made in error by Participants due to such clerical error will be returned, or otherwise credited, to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, the amount of overpayment may be deducted from future benefits payable.

2. **Conformity With Applicable Laws and Grandfathered Health Plan Status**

Any provision of this Plan that is deemed contrary to any applicable law, equitable principle, regulation or court order (if such a court is of competent jurisdiction) or otherwise in non-conformance with the Plan's continuance as a grandfathered health plan under applicable law, will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement, including, but not limited to, stated maximums, Exclusions, or statutes of limitations. It is intended that the Plan will at all times conform to the requirements of applicable law and maintain the Plan's grandfathered status.

3. **Fraud**

Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

4. **Headings**

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

5. **Pronouns**

Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

6. **Word Usage**

Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

7. **No Waiver or Estoppel**

All parts, portions, provisions, and conditions in the Plan, and/or other items addressed in this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no waiver of or estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

8. **Plan Contributions**

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis. The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extent allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the County's obligation with respect to such payments.

In the event that the County terminates the Plan, then as of the effective date of termination, the Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims incurred after the termination date of the Plan.

9. **Right to Receive and Release Information**

The Plan Administrator may, without notice to or consent of any person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, in its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information and HIPAA as well as other releases as requested and as may be necessary to implement this provision.

10. **Written Notice**

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

11. **Right of Recovery**

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Participant or his or her Dependents. See the Recovery of Payments provision for full details.

12. **Statements**

All statements made by the County or by a Participant will, in the absence of fraud, be considered representations and not warranties, and no statements made for the purpose of obtaining benefits under this document will be used in any contest to avoid or reduce the benefits provided by the document unless contained in a written application for benefits and a copy of the instrument containing such representation is or has been furnished to the Participant.

Any Participant who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Participant may be subject to prosecution under U.S. and Texas laws. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both.

13. Protection Against Creditors

To the extent this provision does not conflict with any applicable law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Participant or former Participant, his or her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

14. Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check may be voided and the funds will be retained by this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to any applicable State law(s).

SUMMARY OF BENEFITS

1. **General Limits**

Payment for any of the expenses listed in this Summary of Benefits is subject to all Plan Exclusions, limitations and provisions.

See the Utilization Management section for more information regarding Pre-Certification and/or Notification requirements.

Network and Non-Network Provider Arrangement

The Plan contracts with a medical Provider Network, Aetna Signature Administrators network (www.aetna.com/asa) to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

- A. The Plan provides different levels of benefits based on whether the Participants use a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
 - 1. In the event a Network Provider refers a Participant to a Non-Network Provider for diagnostic testing, x-rays, laboratory services or anesthesia, then charges of the Non-Network Provider will be paid as though the services were provided by a Network Provider.
 - 2. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out-of-Area/out-of-area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.
- B. Except as outlined in "No Surprises Act – Emergency Services and Surprise Bills" below, if the charge billed by a Non-Network Provider for any covered service is higher than the Maximum Allowable Charge determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any Provider, at its discretion.
- C. To receive benefit consideration, Participants may need to submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves, but may in the event of a Network Provider error or failure as regards billing and/or claim submission, to facilitate resolution.
- D. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

If a Participant receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

Read the front and back of the Montgomery County Employee Medical Plan ID card carefully so that you may obtain the maximum benefit from this Plan. You have unrestricted access to any practitioner or facility with this directory (referral not needed except for mental health, substance abuse or alcoholism benefits).

When you select a Preferred Provider, simply call for an appointment and identify yourself as a Participant in the Aetna Signature Administrators network. The Montgomery County Employee Medical Plan ID card should be presented at the time of your appointment or utilization of services. During the year Aetna Signature Administrators network will update the directory. It is responsibility of the Participant to verify and ensure the provider is participating in the network prior to accessing services.

In summary, Aetna Signature Administrators network offers easy access to quality health care, widespread geographic and maximum benefits from the Plan.

2. **Balance Billing**

In the event that a claim submitted by a Network or Non-Network Provider is subject to a medical bill review or medical chart audit and some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator, although the Plan has no control over any Provider's actions, including balance billing.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for any applicable payment of Coinsurances, Deductibles, and out-of-pocket maximums and may be billed for any or all of these.

3. **Choice of Providers**

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other health care Providers are not agents or delegates of the Plan Sponsor, County, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other health care services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other health care Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

4. **Network Provider Information**

The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the applicable phone number or website address.

5. **Claims Audit**

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that exceed the Maximum Allowable Charge or services that are not Medically Necessary and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Maximum Allowable Charge or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to the Maximum Allowable Charge, in accord with the terms of this Plan Document.

6. **No Surprises Act – Emergency Services and Surprise Bills**

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Maximum Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Maximum Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

7. **Continuity of Care**

In the event a Participant is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

The Plan Participant should submit their request in writing to the Utilization Review Manager, Prime Dx, providing the reason for the continuation of care request. If the continuation of care is deemed appropriate, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Participant ceases to be a continuing care patient, whichever is sooner.

For purposes of this provision, "continuing care patient" means an individual who:

- A. is undergoing a course of treatment for a serious and complex condition from a specific Provider,
- B. is undergoing a course of institutional or Inpatient care from a specific Provider,
- C. is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
- D. is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
- E. is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, although Plan benefits will be processed as if the termination had not occurred and the law requires the Provider to continue to accept the previously-contracted amount, the contract itself will have terminated, and thus the Plan may be unable to protect the Participant if the Provider pursues a balance bill.

8. **Transition of Care**

If a Participant is under the care of a Non-Network Provider at the time of joining the Plan, there are a limited number of medical conditions that may qualify for transition of care. If transitional care is appropriate, specific treatment by a Non-Network Provider may be covered at the Network level of benefits for a limited period of time. The Third Party Administrator will review and approve or deny such requests.

Summary of Medical Benefits – Low Deductible Plan Option

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

Calendar Year Maximum Benefits for:			
All Essential Health Benefits			Unlimited
	Network	Non-Network	Limits and Additional Explanation
Deductible, per Calendar Year Office Visit Copayments apply to the Deductible. Network Deductible amounts apply to the Non-Network Deductible. Non-Network Deductible amounts do not apply to the Network Deductible.			
4th Quarter Carryover: Covered Expenses Incurred in and applied toward the Deductible in October, November and December will be applied toward the Deductible in the next Calendar Year.			
Individual	\$250	\$500	
Family Maximum	Not Applicable	Not Applicable	
Per Hospital Confinement	Not Applicable	\$450	This is an additional deductible.
Maximum Out-of-Pocket Amount, per Calendar Year This plan includes Calendar Year and Hospital Confinement Deductibles, Coinsurance and Office Visit Copayments, in the Out-of-Pocket maximum. Network Out-of-Pocket amounts do not apply to the Non-Network Out-of-Pocket limit. Non-Network Out-of-Pocket amounts do not apply Network Out-of-Pocket limit.			
Individual	\$2,250	\$8,000	
Family Maximum	Not Applicable	Not Applicable	

The following table identifies what does and does not apply toward the Network and Non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments	Yes	Yes
Office Visit Copayments	Yes	Yes
Prescription Copayments	No	No
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Allowable Expenses	No	No

Covered Medical Expenses	Network	Non-Network	Limits and Additional Explanation
Advanced Imaging (Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans)	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Pre-certification is required for Non-Emergency.
Allergy Treatment	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to \$1,000 per Calendar Year
Ambulance - Medical Emergency	90% Coinsurance after Deductible	90% Coinsurance after Deductible	Ground, water, rail and air ambulances. No coverage when plan participant is not transported.
Ambulance - Non-Medical Emergency Ambulance	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Pre-certification is required for Non-Emergency transportation.
Anesthesia	90% Coinsurance after Deductible	50% Coinsurance after Deductible	

Covered Medical Expenses	Network	Non-Network	Limits and Additional Explanation
Birthing Center	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Blood & Plasma	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Cardiac Screenings	\$150	\$150	
Chemotherapy	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Chiropractic Care	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to 24 visits per Calendar Year. Maximum combined with Physical and Occupational Therapies
Clinical Trials (Routine Costs)	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Cochlear Implants	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Colonoscopy (Preventive & Diagnostic)	100%	50% Coinsurance after Deductible	Pre-notification required for Non-Emergencies. One preventive or diagnostic colonoscopy is covered per year under this benefit. If more than one received, charges will be paid as any other illness.
COVID-19 Testing	100%, Deductible waived	100%, Deductible waived	
Dialysis, outpatient	100% of MAC Important Note: The plan does not use a preferred provider organization (PPO) for dialysis services. The definition of Maximum Allowable Charge (MAC) is different for Outpatient Dialysis Services than other services. Please review the definitions section for details.		A Covered Person Must: (1) notify [insert UM company name] when Dialysis treatment begins; (2) notify [insert UM company name] when diagnosed with End Stage Renal Disease ("ESRD"); and (3) enroll in Part A and B of Medicare when diagnosed with ESRD. While a Covered Person has ESRD and the Plan is primary, the Plan will pay or reimburse the Covered Person for Medicare Part B premiums.
Durable Medical Equipment	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Glaucoma, Cataract Surgery and Lenses (one set)	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Hearing Aids	Not Covered	Not Covered	
Home Health Care	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to 120 visits per Calendar Year Precertification is required
Hospice Care	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Precertification is required
Family Bereavement Counseling	Not Covered	Not Covered	
Hospital – Inpatient	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Precertification is required. Refer to the section titled "UTILIZATION REVIEW" for additional details.
Infertility Treatment	Not Covered	Not Covered	
Mental Health and Substance Abuse Expenses			
Office Visits	100% after \$25 Copay	50% Coinsurance after Deductible	
All Other	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Precertification is required for inpatient services

Covered Medical Expenses	Network	Non-Network	Limits and Additional Explanation
Newborn Care	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Nutritional Counseling	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Outpatient Diagnostic X-ray and Lab	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Outpatient Emergency Room Services			
Facility	90% Coinsurance after Deductible and \$150 copayment	90% Coinsurance after Network Deductible and \$150 copayment	Copayment waived if admitted
All Other	90% Coinsurance after Deductible	90% Coinsurance after Network Deductible	
Pre-Admission Testing (outpatient), including lab and x-ray	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
Physician Services, including telehealth			
Office Visit	100% after \$25 Copay	50% Coinsurance after Deductible	Copay applies to Office Visit only. All other services subject to deductible/coinsurance.
Lab, X-rays & Surgery	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Inpatient Services	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Pregnancy Expenses	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Preventive Care (One copay applies per visit)			
Bone Density	100% after \$25 Copay	50% Coinsurance after Deductible	
Colorectal Cancer Screening	100% after \$25 Copay	50% Coinsurance after Deductible	Includes digital rectal exam, barium enema and fecal occult blood test.
Immunizations – Child(ren)	100%	100%	
Immunizations – Adult	Not Covered	Not Covered	Adult immunizations are available through the County's employee healthcare clinic, Next Level Urgent Care
Mammogram	100% after \$25 Copay	50% Coinsurance after Deductible	
Pap Smear	100% after \$25 Copay	50% Coinsurance after Deductible	
Physical Exam	100% after \$25 Copay	50% Coinsurance after Deductible	
Proctoscopy, occult blood work, prostate specific antigen (PSA)	100% after \$25 Copay	50% Coinsurance after Deductible	
Well Baby/Child Check up	100% after \$25 Copay	50% Coinsurance after Deductible	
Private Duty Nursing	Not Covered	Not Covered	
Prosthetics, Orthotics, Supplies and Surgical Dressings	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Radiation Therapy	90% Coinsurance after Deductible	50% Coinsurance after Deductible	

Covered Medical Expenses	Network	Non-Network	Limits and Additional Explanation
Second and Third Surgical Opinions	100%	100%	
Skilled Nursing Facility	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Limited to 120 days per Calendar Year. Precertification is required.
Surgery – Care Navigation Program	100%		See section for Care Navigation below.
Surgery – Inpatient	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Precertification is required
Surgery – Outpatient	90% Coinsurance after Deductible	80% Coinsurance after Deductible	Precertification is required
Temporomandibular Joint Disorder (TMJ)	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to \$1,000 per Calendar Year
Therapy Services Autism Spectrum Disorder Treatment Occupational Therapy Physical Therapy Speech Therapy	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to 24 visits per Calendar Year. Maximum combined with Chiropractic Care services. Precertification required after the maximum number of visits.
Transplants	90% Coinsurance after Deductible	Not Covered	Precertification is required. See "Transplants" under the section titled "MEDICAL BENEFITS" for information on the Plan's Centers of Excellence.
Urgent Care Facility <i>A clinic, acute-care facility or walk-in clinic with urgent care hours or walk-in clinic hours providing treatment for urgent care.</i> Next Level Urgent Care All Other Urgent Care	No charge 100% after \$75 Copay	No charge 50% Coinsurance after Deductible	
All Other Covered Services	90% Coinsurance after Deductible	50% Coinsurance after Deductible	

CARE NAVIGATION PROGRAM		
Approved Medical Tourism Providers Only		
Covered Services	Plan Pays	Additional Information/Limitations
Surgical Services	100% deductible waived	Covered Services include all medical costs incurred while receiving treatment or services at an Approved Surgery Center. Pre-certification is required. Refer to the Care Navigation section for details and limitations.
Travel Benefit (When Applicable)	Up to \$1,000* per surgery	Pre-approval of all Travel Benefits is required. Includes transportation, lodging and incidental expenses. Refer to Care Navigation section for details and limitations. *Travel expenses that exceed \$1,000 must be pre-approved
High Tech Radiology at a Preferred Imaging Providers	100% deductible waived	Pre-certification required
Virtual Physical Therapy	100% deductible waived	Pre-certification required
All Other Preferred Care Navigation Providers	100% deductible waived	

IMPORTANT NOTE: This benefit is **ONLY** eligible for members with this Employer's plan as the primary coverage.

Summary of Medical Benefits – High Deductible Plan Option

The following benefits are per Participant per Calendar Year. All benefits are subject to the Maximum Allowable Charge.

Calendar Year Maximum Benefits for:			
All Essential Health Benefits	Unlimited		
	Network	Non-Network	Limits and Additional Explanation
Deductible, per Calendar Year Office Visit Copayments apply to the Deductible. Network Deductible amounts apply to the Non-Network Deductible. Non-Network Deductible amounts do not apply to the Network Deductible.			
4th Quarter Carryover: Covered Expenses Incurred in and applied toward the Deductible in October, November and December will be applied toward the Deductible in the next Calendar Year.			
Individual	\$1,000	\$2,000	
Family Maximum	3 Individuals	3 Individuals	
Per Hospital Confinement	Not Applicable	\$450	This is an additional deductible.
Maximum Out-of-Pocket Amount, per Calendar Year This plan includes Calendar Year and Hospital Confinement Deductibles, Coinsurance and Office Visit Copayments, in the Out-of-Pocket maximum. Network Out-of-Pocket amounts do not apply to the Non-Network Out-of-Pocket limit. Non-Network Out-of-Pocket amounts do not apply Network Out-of-Pocket limit.			
Individual	\$2,000	\$5,750	
Family Maximum	3 Individuals	3 Individuals	

The following table identifies what does and does not apply toward the Network and Non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Payments toward the annual Deductible	Yes	Yes
Coinsurance payments	Yes	Yes
Office Visit Copayments	Yes	Yes
Prescription Copayments	No	No
Charges for non-covered services	No	No
The amounts of any Pre-Certification penalties	No	No
Charges that exceed Allowable Expenses	No	No

Covered Medical Expenses	Network	Non-Network	Limits and Additional Explanation
Advanced Imaging (Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans)	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Pre-certification is required for Non-Emergency
Allergy Treatment	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to \$1,000 per Calendar Year
Ambulance - Medical Emergency	90% Coinsurance after Deductible	90% Coinsurance after Deductible	Ground, water, rail and air ambulances. No coverage when plan participant is not transported.
Ambulance - Non-Medical Emergency Ambulance	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Ground, water, and air ambulances. Pre-certification is required for Non-Emergency transportation.
Anesthesia	90% Coinsurance after Deductible	50% Coinsurance after Deductible	

Covered Medical Expenses	Network	Non-Network	Limits and Additional Explanation
Birthing Center	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Blood & Plasma	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Cardiac Screenings	\$150	\$150	
Chemotherapy	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Chiropractic Care	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to 24 visits per Calendar Year. Maximum combined with Physical and Occupational Therapies
Clinical Trials (Routine Costs)	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Cochlear Implants	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Colonoscopy (Preventive & Diagnostic)	100%	50% Coinsurance after Deductible	Pre-notification required except for Emergencies. One preventive or diagnostic colonoscopy is covered per year under this benefit. If more than one received, charges will be paid as any other illness.
COVID-19 Testing	100%, Deductible waived	100%, Deductible waived	
Dialysis, outpatient	100% of MAC Important Note: The plan does not use a preferred provider organization (PPO) for dialysis services. The definition of Maximum Allowable Charge (MAC) is different for Outpatient Dialysis Services than other services. Please review the definitions section for details.		A Covered Person Must: (1) notify [insert UM company name] when Dialysis treatment begins; (2) notify [insert UM company name] when diagnosed with End Stage Renal Disease ("ESRD"); and (3) enroll in Part A and B of Medicare when diagnosed with ESRD. While a Covered Person has ESRD and the Plan is primary, the Plan will pay or reimburse the Covered Person for Medicare Part B premiums.
Durable Medical Equipment	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Glaucoma, Cataract Surgery and Lenses (one set)	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Hearing Aids	Not Covered	Not Covered	
Home Health Care	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to 120 visits per Calendar Year Precertification is required
Hospice Care	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Precertification is required
Family Bereavement Counseling	Not Covered	Not Covered	
Hospital – Inpatient	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Precertification is required. Refer to the section titled "UTILIZATION REVIEW" for additional details.
Infertility Treatment	Not Covered	Not Covered	
Mental Health and Substance Abuse Expenses			
Office Visits	100% after \$25 Copay	50% Coinsurance after Deductible	
All Other	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Precertification is required for inpatient services

Covered Medical Expenses	Network	Non-Network	Limits and Additional Explanation
Newborn Care	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Nutritional Counseling	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Outpatient Diagnostic X-ray and Lab	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Outpatient Emergency Room Services			
Facility	90% Coinsurance after Deductible and \$150 copayment	90% Coinsurance after Network Deductible and \$150 copayment	Copayment waived if admitted
All Other	90% Coinsurance after Deductible	90% Coinsurance after Network Deductible	
Pre-Admission Testing (outpatient), including lab and x-ray	100% Coinsurance after Deductible	80% Coinsurance after Deductible	
Physician Services, including telehealth			
Office Visit	100% after \$25 Copay	50% Coinsurance after Deductible	Copay applies to Office Visit only. All other services subject to deductible/coinsurance.
Lab, X-rays & Surgery	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Inpatient Services	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Pregnancy Expenses	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Preventive Care (One copay applies per visit)			
Bone Density	100% after \$25 Copay	50% Coinsurance after Deductible	
Colorectal Cancer Screening	100% after \$25 Copay	50% Coinsurance after Deductible	Includes digital rectal exam, barium enema and fecal occult blood test.
Immunizations – Child(ren)	100%	100%	
Immunizations – Adult	Not Covered	Not Covered	Adult immunizations are available through the County's employee healthcare clinic, Next Level Urgent Care
Mammogram	100% after \$25 Copay	50% Coinsurance after Deductible	
Pap Smear	100% after \$25 Copay	50% Coinsurance after Deductible	
Physical Exam	100% after \$25 Copay	50% Coinsurance after Deductible	
Proctoscopy, occult blood work, prostate specific antigen (PSA)	100% after \$25 Copay	50% Coinsurance after Deductible	
Well Baby/Child Check up	100% after \$25 Copay	50% Coinsurance after Deductible	
Private Duty Nursing	Not Covered	Not Covered	
Prosthetics, Orthotics, Supplies and Surgical Dressings	90% Coinsurance after Deductible	50% Coinsurance after Deductible	
Radiation Therapy	90% Coinsurance after Deductible	50% Coinsurance after Deductible	

Covered Medical Expenses	Network	Non-Network	Limits and Additional Explanation
Second and Third Surgical Opinions	100%	100%	
Skilled Nursing Facility	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Limited to 120 days per Calendar Year. Precertification is required.
Surgery – Care Navigation Program	100%		See section for Care Navigation below.
Surgery – Inpatient	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Precertification is required
Surgery – Outpatient	90% Coinsurance after Deductible	80% Coinsurance after Deductible	Precertification is required
Temporomandibular Joint Disorder (TMJ)	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to \$1,000 per Calendar Year
Therapy Services Autism Spectrum Disorder Treatment Occupational Therapy Physical Therapy Speech Therapy	90% Coinsurance after Deductible	50% Coinsurance after Deductible	Up to 24 visits per Calendar Year. Maximum combined with Chiropractic Care services. Precertification required after the maximum number of visits.
Transplants	90% Coinsurance after Deductible	Not Covered	Precertification is required. See "Transplants" under the section titled "MEDICAL BENEFITS" for information on the Plan's Centers of Excellence.
Urgent Care Facility <i>A clinic, acute-care facility or walk-in clinic with urgent care hours or walk-in clinic hours providing treatment for urgent care.</i> Next Level Urgent Care All Other Urgent Care	No charge 100% after \$75 Copay	No charge 50% Coinsurance after Deductible	
All Other Covered Services	90% Coinsurance after Deductible	50% Coinsurance after Deductible	

CARE NAVIGATION PROGRAM		
Approved Medical Tourism Providers Only		
Covered Services	Plan Pays	Additional Information/Limitations
Surgical Services	100% deductible waived	Covered Services include all medical costs incurred while receiving treatment or services at an Approved Surgery Center. Pre-certification is required. Refer to the Care Navigation section for details and limitations.
Travel Benefit (When Applicable)	Up to \$1,000* per surgery	Pre-approval of all Travel Benefits is required. Includes transportation, lodging and incidental expenses. Refer to Care Navigation section for details and limitations. *Travel expenses that exceed \$1,000 must be pre-approved
High Tech Radiology at a Preferred Imaging Providers	100% deductible waived	Pre-certification required
Virtual Physical Therapy	100% deductible waived	Pre-certification required
All Other Preferred Care Navigation Providers	100% deductible waived	

IMPORTANT NOTE: This benefit is **ONLY** eligible for members with this Employer's plan as the primary coverage.

Summary of Benefits - Prescription Drug (Applies to both Low and High Deductible Plans)

The following benefit limits are per Participant:

Prescription Drug Plan	Out-of-Pocket Maximum, per Calendar Year
Individual	Not applicable
Family	Not applicable

A Copayment is the flat dollar amount specified in the Summary of Benefits that a Participant is required to pay for certain covered services. Copayments do not apply to the major medical deductible or out-of-pocket maximum.

Covered Prescription Drug Expenses:	Participating Pharmacy ¹	Non-Participating Pharmacy	Limits ²
Pharmacy Option:			
Tier 1 Copayment, per prescription or refill	The greater of 10% or \$15	Not Covered	See Prescription Drug Benefits section
Tier 2 Copayment, per prescription or refill ³	The greater of 20% or \$25	Not Covered	See Prescription Drug Benefits section
Tier 3 Copayment, per prescription or refill	The greater of 30% or \$35	Not Covered	See Prescription Drug Benefits section
Mail Order Option⁴:			
Tier 1 Copayment, per prescription or refill	\$15	Not Covered	See Prescription Drug Benefits section
Tier 2 Copayment, per prescription or refill ⁵	\$25	Not Covered	See Prescription Drug Benefits section
Tier 3 Copayment, per prescription or refill	\$35	Not Covered	See Prescription Drug Benefits section
Specialty Drug Option: <i>Specialty drugs must be purchased from Maxor Specialty Pharmacy</i>			
Tier 1 Copayment, per prescription or refill	10% copay with maximum Patient Pay of \$15	Not Covered	See Prescription Drug Benefits section
Tier 2 Copayment Coinsurance, per prescription or refill ⁶	20% copay with maximum Patient Pay of \$25	Not Covered	See Prescription Drug Benefits section
Tier 3 Copayment Coinsurance, per prescription or refill	30% copay with a maximum Patient Pay of \$35	Not Covered	See Prescription Drug Benefits section

¹ 100% payment by Plan after Copayment.

² These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

³ Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

⁴ Prescription orders in excess of one refill must be obtained through the Mail Order Option in order to be eligible for benefits under the Plan.

⁵ Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

⁶ Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

Drug Manufacturer Assistance Programs

Any amounts paid toward Participant responsibility which were paid or reimbursed by manufacturer assistance programs, copay cards, or similar patient assistance programs from a third party do not accrue toward the Deductible or annual out-of-pocket maximum when the Drug in question is a name brand, non-formulary, brand name or specialty drug and there is a medically appropriate generic available.

MEDICAL BENEFITS

Medical Benefits

These medical benefits will be payable as shown in the Summary of Medical Benefits or as otherwise outlined in this Plan. Subject to the Plan's provisions, limitations and Exclusions, the following are covered major medical benefits:

1. **Advanced Imaging.** Charges for advanced imaging including: Computed Tomographic (CT) studies, Coronary CT angiography, MRI/MRA, nuclear cardiology, nuclear medicine, and PET scans. Covered Expenses include the readings of these medical tests/scans.
2. **Allergy Services.** Charges related to the treatment of allergies limited to the maximum stated in the Summary of Medical Benefits.
3. **Air Ambulance (See Summary of Benefits).**

Covered Expenses will be payable at the lesser of the following:

1. A contracted amount as established by a Network Provider or other discounting contract.
2. 125% of the allowable charge established by application of the Medicare Ambulance Fee Schedule.
3. The billed charge if less than 1 or 2 above.

Benefits are provided for air ambulance transportation only if the Plan Administrator determines that the Participant's condition, the type of service required for the treatment of the Participant's condition, and the type of facility required to treat the Participant's condition justify the use of air ambulance instead of another means of transport. This Plan will only cover air ambulance transportation when no other method of transportation is appropriate (including emergency ground transport).

The determination of whether air ambulance transport for a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

4. **Ambulance (See Summary of Benefits).** Covered Expenses for professional ambulance, including approved available ground, water and rail transportation, to a local Hospital, or transfer to the nearest facility having the capability to treat the condition.
5. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided.
6. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff.
7. **Birth Center.** Services of a birthing center for Medically Necessary care provided within the scope of its license.
8. **Blood/Blood Derivatives.** Charges for blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan shall also cover processing, storage, and administrative services for autologous blood (a patient's own blood) when a Participant is scheduled for Surgery that can be reasonably expected to require blood.
9. **Cataracts.** Cataract surgery and one set of lenses (contacts or frame-type) following the surgery.
10. **Chemotherapy.** Charges for chemotherapy, including materials and services of technicians.
11. **Chiropractic Care.** Spinal adjustment and manipulation, x-rays for manipulation and adjustment, and other modalities performed by a Physician or other licensed practitioner, as limited in the Summary of Medical Benefits.
12. **Cochlear Implants.** Charges for cochlear implants for Participants who are certified as deaf or hearing impaired by a Provider. Prior authorization is recommended.

13. **Contraceptives.** The Plan will also cover contraception-related services, including the initial visit to the prescribing Physician and any follow up visits or Outpatient services.
14. **COVID-19 (2019 Novel Coronavirus).** Covered Expenses associated with testing for and treatment of COVID-19 include the following:
- **Diagnostic Tests.** The following items are covered at 100%, Deductible waived, as provided in the Families First Coronavirus Response Act (FFCRA) and Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and notwithstanding any otherwise-applicable Medical Necessity or Experimental and/or Investigational requirements, and do not require Pre-Certification. These items are paid at the negotiated rate, if one exists. If no negotiated rate exists, the Plan will pay the cash price publicly posted on the Provider's website, or such other amount as may be negotiated by the Provider and Plan.
 - In vitro diagnostic products for the detection of SARS-CoV-2 or the Diagnosis of the virus that causes COVID-19 (including all costs relating to the administration of such in vitro diagnostic products) which satisfy one of the following conditions:
 - That are approved, cleared, or authorized by the FDA;
 - For which the developer has requested or intends to request emergency use authorization under Section 564 of the Federal Food, Drug, and Cosmetic Act, unless and until such emergency use authorization request has been denied or the developer does not submit a request within a reasonable timeframe;
 - That are developed in and authorized by a State that has notified the Secretary of Health and Human Services of its intention to review tests intended to diagnose COVID-19; or
 - That are deemed appropriate by the Secretary of Health and Human Services.
 - Items and services furnished during an office visit (including both in-person and telehealth), urgent care visit, or emergency room visit which results in an order for or administration of an in vitro diagnostic product described above. Such items and services must relate to the furnishing of such diagnostic product or evaluation of the individual for purposes of determining the need for such product.
 - **Qualifying Coronavirus Preventive Services.** The following items are covered at 100%, Deductible waived, and do not require Pre-Certification.
 - An item, service, or immunization that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; and
 - An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.
 - **Inpatient Hospital Quarantines.** There may be times when Participants with the virus need to be quarantined in a Hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the Hospital for public health reasons. Such charges will not be denied solely because otherwise-applicable Medically Necessary requirements would not indicate a need for a private room.
 - **Telehealth and Other Communication-Based Technology Services.** Participants can communicate with their doctors or certain other practitioners without going to the doctor's office in person. This is recommended if a Participant believes he or she has COVID-19 symptoms.

The above benefits are specific to Diagnosis and treatment of COVID-19. Participants who have been diagnosed with COVID-19 will continue to receive all other benefits covered by the Plan, in accordance with the Plan's guidelines.

15. **Dental Services—Accident Only.** Charges made for a continuous course of dental treatment started within six months from the date of the Injury to sound natural teeth.

Note: No charge will be covered under this Plan for dental and oral Surgical Procedures involving orthodontic care of teeth (unless these are otherwise covered under Oral Surgery below), periodontal disease, and preparing the mouth for fitting of or continued use of dentures.

16. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures.
17. **Dialysis.** Dialysis means any service, supply, equipment or drug utilized in connection with hemodialysis or peritoneal dialysis.

18. **Durable Medical Equipment.** Charges for rental, up to the purchase price, of Durable Medical Equipment, including glucose home monitors for insulin dependent diabetics. At its option, and with its advance written approval, the Plan may cover the purchase of such items when it is less costly and more practical than rental. The Plan does not pay for any of the following:
1. Replacements or repairs. *NOTE: Replacement of Durable Medical Equipment when Medically Necessary due to a physiological change to the patient, due to normal wear and tear of an item or the existing equipment is damaged and cannot be made serviceable.*
 2. The rental or purchase of items which do not fully meet the definition of "Durable Medical Equipment."
19. **Foot Disorders.** Surgical treatment of foot disorders, including associated services, performed by a licensed Physician (excluding routine foot care).
20. **Glaucoma.** Treatment of glaucoma.
21. **Growth Hormone Treatment.** Treatment, including diagnosis, in connection with growth hormone deficiencies for a dependent child.
22. **Habilitative Services (including Autism therapies).** These services include:
1. **Occupational Therapy.** Treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
 2. **Physical Therapy.** Treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
 3. **Speech-Language Pathology.** Treatment for speech delays and disorders.
- See the Summary of Medical Benefits for treatment and/or frequency limitations.
23. **Hearing Exams.** Charges for Hearing Exams for newborns to thirty (30) days of age and Eligible Expenses for Medically Necessary diagnostic follow up care related to the screening to age twenty-four (24) months.
24. **Home Health Care.** Charges for Home Health Care services and supplies are covered only for care and treatment of an Illness or Injury when Hospital or Skilled Nursing Facility confinement would otherwise be required, subject to the maximum stated in the Summary of Medical Benefits. The Diagnosis, care, and treatment must be certified by the attending Physician and be contained in a home health care plan. Charges by a Home Health Care Agency for any of the following:
1. Registered Nurses or Licensed Practical Nurses.
 2. Certified home health aides under the direct supervision of a Registered Nurse.
 3. Registered therapist performing physical, occupational or speech therapy.
 4. Physician calls in the office, home, clinic or outpatient department.
 5. Services, Drugs and medical supplies which are Medically Necessary for the treatment of the Participant that would have been provided in the Hospital, but not including Custodial Care.
 6. Rental of Durable Medical Equipment or the purchase of this equipment if economically justified, whichever is less.
- NOTE:** *Transportation services are not covered under this benefit.*
25. **Hospice Care.** Charges relating to Hospice Care, provided the Participant has a life expectancy of six months or less, subject to the maximum stated in the Summary of Medical Benefits. Covered Hospice expenses are limited to:
1. Room and Board for confinement in a Hospice.
 2. Ancillary charges furnished by the Hospice while the patient is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
 3. Medical supplies, Drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.

4. Physician services and nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Home care furnished by a Hospital or Home Health Care Agency, under the direction of a Hospice, including Custodial Care if it is provided during a regular visit by a Registered Nurse, a Licensed Practical Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, Psychologists or counselors.
8. Nutrition services provided by a licensed dietitian.
9. Respite care.

The Hospice Care program must be renewed in writing by the attending Physician as requested by Utilization Review Manager. If Hospice Care is expected to exceed six months, the Physician is required to recertify the patient's status and further hospice needs with the Utilization Review Manager. Hospice Care ceases if the terminal illness enters remission.

26. Hospital. Charges made by a Hospital for:

1. Inpatient Treatment
 - a. Daily semi private Room and Board charges.
 - b. Intensive Care Unit (ICU) and Cardiac Care Unit (CCU) Room and Board charges.
 - c. General nursing services.
 - d. Medically Necessary services and supplies furnished by the Hospital, other than Room and Board.
2. Outpatient Treatment
 - a. Emergency room.
 - b. Treatment for chronic conditions.
 - c. Physical therapy treatments.
 - d. Hemodialysis (including procedure to switch to peritoneal dialysis).
 - e. X-ray, laboratory and linear therapy.

27. Laboratory and Pathology Services. Charges for x-rays, diagnostic tests, labs, and pathology services.

28. Mastectomy. The Federal Women's Health and Cancer Rights Act contains coverage requirements for breast cancer patients who elect reconstruction in connection with a Mastectomy. The Federal law requires most group health plans that provide Mastectomy coverage to also cover breast reconstruction Surgery and prostheses following Mastectomy.

While this Plan opts out of this requirement, individuals receiving benefits for a Medically Necessary Mastectomy will also receive coverage for:

1. Reconstruction of the breast on which the Mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses and physical complications from all stages of Mastectomy, including lymphedemas.

The reconstruction of the breast will be done in a manner determined in consultation with the attending Physician and the patient.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy coverage, and will be provided in consultation with the Participant and his or her attending Physician.

29. **Medical Foods.** Medical foods are considered a covered charge if intravenous therapy (IV) or tube feedings are Medically Necessary. Medical foods taken orally are not covered under the Plan, except for PKU formula when Medically Necessary.
30. **Medical Supplies.** Dressings, casts, splints, trusses, braces and other Medically Necessary medical supplies, with the exception of dental braces or corrective shoes, but including syringes for diabetic and allergy Diagnosis, and lancets and chemstrips for diabetics.
31. **Mental Health and Substance Abuse Benefits.** Benefits are available for Inpatient or Outpatient care for mental health and Substance Abuse conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the Diagnosis when rendered by a covered Provider.

Benefits are available for Residential Treatment Facility, Partial Hospitalization, and Intensive Outpatient Services.

32. **Midwife Services.** Benefits for midwife services performed by a certified nurse midwife (CNM) who is licensed as such and acting within the scope of his/her license. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries.
33. **Morbid Obesity.** Charges related to morbid obesity (which is the lesser of 100 pounds over normal weight or twice normal weight), only when the treatment meets the Plan's Medical Necessity criteria. To include surgical treatment, revisions and complications arising from surgery. The surgery and revision is subject to one surgical procedure per lifetime. Treatment for complications arising from this surgery is not included in the one procedure limit.
34. **Newborn Care.** Hospital and Physician nursery care for newborns who are Children of the Employee or spouse and properly enrolled in the Plan, as set forth below. Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:
 1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
 2. The following Physician services for well-baby care during the newborn's initial Hospital confinement at birth:
 - a. The initial newborn examination and a second examination performed prior to discharge from the Hospital.
 - b. Circumcision.

***NOTE:** The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage.*

35. **Nursing Services.** Services of a Registered Nurse or Licensed Practical Nurse.
36. **Nutritional Counseling.** Charges for nutritional counseling for the management of a medical condition that has a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Physician.
37. **Oral Surgery.** Oral surgery in relation to the bone, including tumors, cysts and growths not related to the teeth, and extraction of soft tissue impacted teeth by a Physician or Dentist. Removal of bony impacted wisdom teeth is covered.
38. **Physician Services.** Services of a Physician for Medically Necessary care, including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care and surgical opinion consultations.
39. **Pregnancy Expenses.** Expenses attributable to a Pregnancy. Benefits for Pregnancy expenses are paid the same as any other Illness.

In accordance with the Summary of Medical Benefits and this section, benefits for the care and treatment of Pregnancy that are covered will be subject to all applicable Plan limitations and maximums (if any), and are payable in the same manner as medical or surgical care of an Illness.
40. **Preventive Care.** Charges for Preventive Care services, as defined in the Summary of Medical Benefits.
41. **Prosthetics, Orthotics, Supplies and Surgical Dressings.** Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices when a surgical procedure is performed, but excluding orthopedic shoes and other supportive devices for the feet.
42. **Radiation Therapy.** Charges for radiation therapy and treatment.
43. **Second (and Third) Surgical Opinions.** Charges for second surgical opinions. Notification to Utilization Review Manager is highly recommended.
44. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a convalescent care facility, up to the limits set forth in the Summary of Medical Benefits, in connection with convalescence from an Illness or Injury (excluding drug addiction,

chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders) for which the Participant is confined.

45. **Sterilization (male and female).** Charges related to sterilization procedures.
46. **Surgery.** Surgical operations and procedures, unless otherwise specifically excluded under the Plan, and limited as follows:
 1. Multiple procedures adding significant time or complexity will be allowed at:
 - a. One hundred percent (100%) of the Maximum Allowable Charge for the first or major procedure.
 - b. Fifty percent (50%) of the Maximum Allowable Charge for the secondary and subsequent procedures.
 - c. Bilateral procedures which add significant time or complexity, which are provided at the same operative session, will be allowed at one hundred percent (100%) of the Maximum Allowable Charge for the major procedure, and fifty percent (50%) of the Maximum Allowable Charge for the secondary or lesser procedure.
 2. The Maximum Allowable Charge for services rendered by an assistant surgeon will be limited to twenty percent (20%) of the Maximum Allowable Charge identified for the surgeon's service.
 3. No benefit will be payable for incidental non-Medically Necessary procedures, performed during a single operative session with a Covered surgery.
47. **Surgical Treatment of Jaw.** Surgical treatment of Illnesses, Injuries, fractures and dislocations of the jaw by a Physician or Dentist. (For Temporomandibular Joint Disorder, please refer to the separate benefit herein.)
48. **Telehealth.** Charges for any Medically Necessary services, for which benefits are otherwise provided by the Plan, when those services are provided via audio or video communications.
49. **Temporomandibular Joint Disorder.** Charges for the Diagnosis and treatment of, or in connection with, temporomandibular joint disorders or myofascial pain dysfunction subject to benefit payment maximums shown in the Summary of Medical Benefits.
50. **Therapy Services.** Services for individual therapy are covered on an Inpatient or Outpatient basis. They are services or supplies used for the treatment of an Illness or Injury and include:
 1. **Cardiac Therapy.** Charges for cardiac therapy.
 2. **Cognitive Therapy.** Charges for cognitive therapy.
 3. **Occupational Therapy.** Rehabilitation treatment or services rendered by a registered occupational therapist, under the direct supervision of a Physician, in a home setting or at a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing outpatient facility.
 4. **Physical Therapy.** Rehabilitation treatment or services rendered by a physical therapist, under direct supervision of a Physician, in a home setting or a facility or Institution whose primary purpose is to provide medical care for an Illness or Injury, or at a free-standing duly licensed outpatient therapy facility.
 5. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan.
 6. **Speech Therapy.** Speech therapy, for Rehabilitation purposes, by a Physician or qualified speech therapist, when needed due to an Illness or Injury (other than a functional Nervous Disorder) or due to Surgery performed as the result of an Illness or Injury, excluding speech therapy services that are educational in any part or due to articulation disorders, tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, hearing loss which is not medically documented or similar disorders.

See the Summary of Medical Benefits for treatment and/or frequency limitations.

51. **Transplants.** Organ or tissue transplants are covered for the following human to human organ or tissue transplant procedures:
 1. Bone marrow.
 2. Heart.
 3. Lung.
 4. Heart and lung.

5. Liver.
6. Pancreas.
7. Kidney.
8. Cornea.

Pre-certification is required or no benefits will be payable. The Utilization Review Manager, Prime Dx (1-800-477-4625), will designate Solid Organ and/or Tissue Transplant Providers within the **SPECIALTY TRANSPLANT NETWORK / CENTERS OF EXCELLENCE** that Participants are required to use.

In addition, the Plan will cover any other transplant that is not Experimental.

Recipient Benefits

Covered Expenses will be considered the same as any other illness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered Expenses include:

1. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part.
2. Services and supplies furnished by a Provider.
3. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described herein will be covered. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

When both the person donating the organ and the person receiving the organ are Participants, each will receive benefits under the Plan.

Donor Benefits

The Plan covers donation-related services for actual or potential donors, whether or not they are Participants, as long as the transplant recipient is a Participant. The Plan will cover these costs, provided such costs are not covered in whole or in part by any other source other than the donor's family or estate. This includes, but is not limited to, other insurance, including self-funded medical plans, grants, foundations, and government programs.

52. **Wigs.** Charges associated with the initial purchase of a wig after chemotherapy or radiation therapy.

Medical Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

1. **Abortion.** For an elective or therapeutic abortion unless such abortion is necessary due to an acute life-threatening physical condition with respect to a pregnant covered participant strictly in compliance with and as authorized by Texas law, as amended.
2. **Acupuncture.** Relating directly or indirectly to acupuncture, including acupuncture provided in lieu of anesthetic.
3. **Alternative Medicine.** For holistic or homeopathic treatment, naturopathic services, and thermography, including drugs.
4. **Bereavement Counseling.**
5. **Biofeedback.** For biofeedback.
6. **Chelation Therapy.**
7. **Dental Care.** For normal dental care benefits, including any dental, gum treatments, or oral surgery, except as otherwise specifically provided herein.

8. **Education or Training Program.** Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.
9. **Examinations.** Any health examination required by any law of a government to secure insurance or school admissions or professional or other licenses, except as required under applicable federal law.
10. **Foot Care (Routine).** Treatment of the feet resulting from bursitis, tendinitis, tarsalgia, metatarsalgia, weak, unstable or flat feet, bunions, corns and calluses, unless an open cutting operation is performed; or for treatment of toenails, unless at least part of the nail root or matrix is removed, or purchase of orthopedic shoes or other orthotic devices for support of the feet unless an open cutting operation is performed. The initial office visit, including x-rays, for the purposes of diagnosis will be allowed.
11. **Hair Pieces.** For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness. **NOTE:** *This Exclusion does not apply to hair pieces and wigs that are covered under the Plan for patients who are undergoing chemotherapy or radiation.*
12. **Hearing Aids.** For hearing aids or examinations for the prescription, fitting, and/or repair of hearing aids, except as specifically provided herein.
13. **Hypnosis.** Related to the use of hypnosis.
14. **Immunizations.** Except as otherwise indicated, for adult immunizations and vaccinations, as well as all immunizations for the purpose of travel outside of the United States.
15. **Impregnation and Infertility Treatment.** Following charges related to Impregnation and Infertility Treatment: artificial insemination, fertility Drugs, G.I.F.T. (Gamete Intrafallopian Transfer), impotency Drugs such as Viagra™, in-vitro fertilization, surrogate mother (unless the surrogate is a Participant, in which case the Pregnancy expenses will be covered in accordance with the Plan provisions), donor eggs, collection or purchase of donor semen (sperm) or oocytes (eggs), and freezing of sperm, oocytes, or embryos, or any type of artificial impregnation procedure, whether or not such procedure is successful.
16. **Marijuana.** For marijuana or marijuana-derived substances or compounds (like THC/CBD oil), even if the Participant has a prescription and marijuana is legal under the laws of the state in which he or she lives.
17. **Massage Therapy.**
18. **Nutritional Supplements.** For nutritional supplements, except as specifically provided herein.
19. **Organ Transplants.** Related to donation of a human organ or tissue, except as specifically provided.
20. **Orthognathic Disorders.**
21. **Orthopedic Shoes.** For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.
22. **Personal Convenience Items.** For equipment that does not meet the definition of Durable Medical Equipment, including escalators, elevators, sauna, steam baths, swimming pools, hot tubs, blood pressure monitor, air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician.
23. **Private Duty Nursing.** Private duty nursing.

24. **Repair of Purchased Equipment.** For maintenance and repairs needed due to misuse or abuse are not covered.
 25. **Replacement Braces.** For replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.
 26. **Sex Assignment/Reassignment.** Related to a sex change operation.
 27. **Sexual Dysfunction Therapy or Surgery.** For treatment for sexual dysfunction of inadequacy, which includes implants, pumps and related hormones and/or drug therapy. Expenses for drug therapy may be considered eligible under this Plan when sexual dysfunction of inadequacy is not the primary diagnosis.
 28. **Sleep Disorders.** Sleep disorders unless there is medical diagnosis. If there is not a sleep apnea or other eligible medical diagnosis after the testing, only the office visit and the testing for diagnosis on an outpatient basis will be considered eligible expense.
 29. **Sterilization Reversal.** For sterilization procedure reversal.
 30. **Travel.** For travel, whether or not recommended by a Physician, except as specifically provided herein.
 31. **Vision Care.** Expenses for the following:
 1. For routine vision examinations, eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Illness or Injury).
 2. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.
 3. Vision therapy (orthoptics) and supplies.
 4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.
- All other ophthalmological, Medically Necessary, services are covered to the full extent of applicable limits under the Plan.
32. **Vitamins.** For vitamins except as otherwise indicated herein.

UTILIZATION MANAGEMENT

"Utilization Management" consists of several components to assist Participants in staying well: providing optimal management of chronic conditions, support, and service coordination during times of acute or new onset of a medical condition. The scope of the program includes Hospital admission pre-certification, continued stay review, length of stay determination, discharge planning, and case management. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan. In order to maximize Plan reimbursements, please read the following provisions carefully.

Services that Require Pre-Certification or Notification

The following services will require Pre-Certification or Notification (or reimbursement from the Plan may be reduced):

1. Colonoscopies.
2. Dialysis.
3. Durable Medical Equipment, rental greater than two months, or purchase in excess of billed per date of service.
4. Home Health Services.
5. Hospice Care
6. High Tech Imaging.
7. Implantable devices (the use of).
8. Infusion services.
9. Inpatient hospitalization, except as otherwise provided for emergencies, as described below.
10. MRI/PET/CT scans.
11. Rehab program (such as cardiac, pain management, pulmonary).
12. Residential Treatment Facility programs.
13. Skilled Nursing Facility stays.
14. Surgeries (inpatient and outpatient).
15. Therapy services:
 - a. Applied Behavior Analysis (ABA) therapy.
 - b. Cardiac therapy.
 - c. Chiropractic Care in excess of the limit shown on the Summary of Benefits
 - d. Cognitive therapy.
 - e. Occupational therapy.
 - f. Physical therapy.
 - g. Respiration therapy.
 - h. Speech therapy.
16. Transplant candidacy evaluation and transplant (organ and/or tissue).

Remember that although the Plan will automatically pre-certify a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours for a cesarean delivery, it is important that the Participant has his or her Physician call to obtain Pre-Certification if there is a need to have a longer stay.

Pre-Certification does not verify eligibility for benefits nor guarantee benefit payments under the Plan. It is the Participant's responsibility to verify that the above services have been pre-certified as outlined below.

Notification is requested for the following service(s):

- All observation stays in excess of 23 hours.

Pre-Certification or Notification Procedures and Contact Information

The Utilization Management Service is simple and easy for Participants to use. Whenever a Participant is advised that Hospital care is needed, it is the Participant's responsibility to call the Utilization Review Manager at its toll free number, which is 1-800-477-4625. The review process will continue, as outlined below, until the Participant is discharged from the Hospital.

Urgent Care or Emergency Admissions:

If a Participant needs medical care for a condition which could seriously jeopardize his or her life, he or she should obtain such care without delay, and communicate with the Plan as soon as reasonably possible.

If a Participant must be admitted on an Emergency basis, the Participant or an individual acting on behalf of the Participant should follow the Physician's instructions carefully and contact the pre-certification department as follows:

1. For Emergency admissions after business hours on Friday, on a weekend or over a holiday weekend, a call to the pre-certification department must be made within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient.
2. For Emergency admissions on a weekday, a call to the pre-certification department must be made within 24 hours after the admission date, by or on behalf of the covered patient.

If a medical service is provided in response to an Emergency situation or urgent care scenario, prior approval from the Plan is not required. The Plan will require notice within 72 hours after the admission date, but no later than the first business day following the Emergency admission, by or on behalf of the covered patient. Such a claim shall then be deemed to be a Post-service Claim.

Failure to initiate Emergency admission review will result in a penalty for non-compliance and benefits for covered services may be reduced by \$500 per hospitalization to the Participant. Such penalty will be the sole responsibility of, and payable by, the Participant.

Non-Emergency Admissions:

For Inpatient Hospital stays that are scheduled in advance, a call to the pre-certification department should be completed as soon as possible before actual services are rendered. Once the pre-certification call is received, it will be routed to an appropriate review specialist who will create an on-line patient file. The review specialist will contact the Participant's attending Physician to obtain information and to discuss the specifics of the admission request. If appropriate, alternative care will be explored with the Physician.

If, after assessing procedure necessity, the need for an Inpatient confinement is confirmed, the review specialist will determine the intensity of management required and will remain in contact with the Physician or Hospital during the confinement.

If, at any time during the review process, Medical Necessity cannot be validated, the review specialist will refer the episode to a board certified Physician advisor who will immediately contact the attending Physician to negotiate an appropriate treatment plan. At the end of the Hospital confinement, the review specialist is also available to assist with discharge planning and will work closely with the attending Physician and Hospital to ensure that medically appropriate arrangements are made.

Pre-Certification Penalty

The program requires the support and cooperation of each Participant. If a Participant follows the instructions and procedures, he or she will receive the normal Plan benefits for the services. However, if a Participant fails to notify the pre-certification department of any services listed in the provision entitled "Services that Require Pre-Certification or Notification," benefits may be reduced by \$500. The Participant will be responsible for payment of the part of the charge that is not paid by the Plan.

NOTE: If a Participant's admission or service is determined to not be Medically Necessary, he or she may pursue an appeal by following the provisions described in the Claims Procedures; Payment of Claims section of this document. The Participant and Provider will be informed of any denial or non-certification in writing.

Pre-Admission Testing

If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an Outpatient basis within seven days prior to such Hospital admission will be paid as outlined in the Summary of Benefits, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

Second and Third Surgical Opinion

If a Physician recommends Surgery for a Participant, the Participant may request a second opinion as to whether or not the Surgery is Medically Necessary.

In addition, the Plan recommends that a second opinion be obtained prior to the following Surgeries:

1. Adenoidectomy.
2. Bunionectomy.
3. Cataract removal.
4. Coronary Bypass.
5. Cholecystectomy (removal of gallbladder).
6. Dilation and curettage.
7. Hammer Toe repair.
8. Hemorrhoidectomy.
9. Herniography.
10. Hysterectomy.
11. Laminectomy (removal of spinal disc).
12. Mastectomy.
13. Meniscectomy (removal of knee cartilage, including arthroscopic approach).
14. Nasal surgery (repair of deviated nasal septum, bone or cartilage).
15. Prostatectomy (removal of all or part of prostate).
16. Release for entrapment of medial nerve (Carpal Tunnel Syndrome).
17. Tonsillectomy.
18. Varicose veins (tying off and stripping).

When a second opinion is requested, the Plan will pay the Maximum Allowable Charge Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician use current. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

In all cases where a second opinion is requested, the original recommendation for Surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended Surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

Case Management

Case management is a preemptive coordination of a Participant's care in cases where the medical condition is or is expected to be serious, chronic, or when the cost of treatment is expected to be significant. This program provides for a case manager who monitors Participants and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same Diagnosis.

CARE NAVIGATION (A Medical Tourism Program)

Domestic Approved Surgery Centers

Participants have access to certain Approved Surgery Centers offering transparent pricing to receive surgical treatments when a treating physician(s) recommends certain eligible, medically necessary treatment or services covered by this Plan (Covered Services) and the participant elects to receive treatment or services at that facility. Participants are not required to access an Approved Surgery Center, however, the Plan encourages participants to consider all options available when planning for an upcoming surgical procedure.

The Covered Services performed at these Approved Surgery Centers will be paid according to the Summary of Benefits.

Covered Services include all medical costs incurred while receiving treatment or services at the Approved Surgery Centers as well as a travel benefit (See Medical Tourism Schedule of Benefits for details). Travel benefits are only covered by the Plan if the travel and lodging is reserved, scheduled and approved by the Plan in advance. If the only option for surgery is at a location where the maximum Travel Benefit will be exceeded, approval of an extended Travel Benefit may be provided by Prime Dx to cover such travel costs. Prior approval is required. If these conditions are met, the Plan covers expenses for travel and lodging for the participant and one adult companion for the following expenses:

- Transportation for the participant and one adult companion who is traveling on the same day(s) to and/or from the site of treatment for a surgical episode of care which typically includes a preoperative evaluation, the surgical procedure and necessary post-operative follow-up. Reasonable transportation expenses may include:
 - Parking expenses at or transportation to and from the member's airport of origin
 - Airfare
 - Ground transportation from airport to hotel, between hotel and doctor's office for consultation, between hotel and surgery center, and from hotel to airport.
 - Mileage reimbursement at the IRS rate for the most direct route between the participant's home and the Approved Surgery Center facility (in lieu of airfare and ground transportation)
- Lodging: One-room accommodation at a Plan-approved hotel. Room and taxes only. Incidentals (Wi-Fi, etc. not included)
- Meals and Incidentals Expense Benefit
 - Provides \$50 per day to cover expenses for the participant while not admitted to the hospital and \$50 per day for one adult companion. Expense benefits are limited to the surgical episode days, and will not be paid for the participant during any required inpatient stay.

Certain examinations, tests, treatment or other medical services may be required prior to or following travel. Any Covered Services performed for pre and post care shall be subject to the coverage limits and other terms of the Plan. Subsequent services connected to the initial procedure will also be subject to the coverage limits and other terms of the Plan.

The determination of medical necessity will be performed by the Approved Surgery Centers physician(s) upon receipt and review of all applicable medical records unless stated otherwise.

Pre-Notification Requirement:

If covered services have been recommended, the Plan Participant must contact your Nurse Advocate at 833-864-4316 or nurseadvocate@boonchapman.com. Except in an urgent or emergency care situation, notification is required at least three (3) business days before any/all procedures scheduled in advance including, but not limited to the following:

- inpatient procedures;
- outpatient procedures;
- imaging services;
- physical therapy; and
- diagnostic testing.

PREScription DRUG BENEFITS

Participating pharmacies ("Participating Pharmacies") have contracted with the Plan to charge Participants reduced fees for covered Drugs. MaxorPlus is the administrator of the prescription drug plan. Participants will be issued an identification card to use at the pharmacy at time of purchase. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage. No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of the volume buying, MaxorPlus, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The copayments applied to each prescription are reflected on the Summary of Benefits. Prescription copayments do not count towards any deductible or out-of-pocket maximums under the Plan.

Covered Expenses

The following are covered under the Plan:

- A. **Acne Control.** Drugs that help manage the severity and frequency of acne outbreaks that cannot be purchased over-the-counter. Prior authorization required for ages 40 and over.
- B. **Allergy Sera.** Charges for allergy sera.
- C. **Bee Sting Kits.** Charges for EPI PEN and Ana Kit.
- D. **Compounded Prescriptions (must contain one covered legend drug).** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. Prior authorization required if over \$100.
- E. **Contraceptives.** Prescription contraception and contraception-related services.
- F. **Drug Efficacy Study Implementation (DESI) Drugs.** Charges for DESI Drugs.
- G. **Diabetes.** Insulins, insulin syringes and needles, diabetic supplies – legend, diabetic supplies – over-the-counter, and glucose test strips, when prescribed by a Physician.
- H. **Growth Hormones (Dependent children only).** Charges for growth hormones. Prior authorization required.
- I. **Imitrex Injection.** Charges for Imitrex injections (migraine auto-injector).
- J. **Immunologicals.** Charges for immunologicals (vaccines).
- K. **Injectables.** A charge for injectables.
- L. **Legend Drugs.**
 - 1. Class V Drugs.
 - 2. Diabetic Supplies.
 - 3. Diagnostics.
 - 4. Legend Drugs with over-the-counter equivalents.
 - 5. Pre natal vitamins when prescribed by a Participant's Physician to be used during pregnancy.
 - 6. Vitamins prescribed by a Participant's Physician if deemed Medically Necessary for an Injury or Illness not otherwise excluded. Prior authorization required.
- M. **Medical Devices and Supplies.** Charges for legend and over the counter medical devices and supplies.

N. **Non-Insulin and Insulin Syringes/Needles.** Charges for insulin and non-insulin syringes and needles.

O. **Required by Law.** All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below.

Limitations

The benefits set forth in this section will be limited to:

Dosages.

- With respect to the Pharmacy Option, any one prescription is limited to a 30 day supply.
- With respect to the Mail Order Option, any one prescription is limited to a 90 day supply.
- With respect to the Specialty Drug Option, any one prescription is limited to a 90 day supply.

Refills.

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.

Exclusions

In addition to the General Limitations and Exclusions section, the following are not covered by the Plan:

1. **Administration.** Any charge for the administration of a covered Drug.
2. **Anorexiant.** Anorexiant (weight loss Drugs).
3. **Anti-Aging Products.** Drugs intended to affect the structure or function of the skin that cannot be purchased over-the-counter.
4. **Consumed Where Dispensed.** Any Drug or medicine that is consumed or administered at the place where it is dispensed.
5. **Devices.** Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device.
6. **Experimental Drugs.** Experimental Drugs and medicines, even though a charge is made to the Participant.
7. **Fertility Agents.** Charges for fertility agents.
8. **Immunizations (Adult).** Immunization agents or biological sera unless required to be covered otherwise under the Plan or under applicable law.
9. **Impotency.** A charge for impotency medication, including Viagra.
10. **Institutional Medication.** A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises.
11. **Investigational Use Drugs.** A Drug or medicine labeled "Caution – limited by Federal law to Investigational use".
12. **No Charge.** A charge for drugs which may be properly received without charge under local, State or Federal programs. The Participant cannot be charged for said drugs.
13. **Non-Participating Pharmacy.** A drug or medicine purchased at a non-participating pharmacy.
14. **Non-Prescription Drug or Medicine.** A drug or medicine that can legally be bought without a prescription, except for injectable insulin.

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15. **Occupational.** Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law.
 16. **Over-the-Counter Drugs.** Charges for over-the-counter drugs:
 17. **Rogaine.** Charges for Rogaine (topical minoxidil).
 18. **Specialty Drugs not purchased at Maxor Specialty Pharmacy.** Specialty drugs purchased at a pharmacy other than Maxor Specialty (866-629-6779) are not covered.
 19. **Vitamins.** Vitamins, except as otherwise indicated.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Participants. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Participant's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Participant's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses a Participant's personal health information. It also describes certain rights the Participant has regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling 1-936-760-6935.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.
2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. **Treatment, Payment and Health Care Operations:** The Plan has the right to use and disclose a Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. **Business Associates:** The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Participant's information.
3. **Other Covered Entities:** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care

operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Participant has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes;
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. **Disclosures to Participants:** The Plan is required to disclose to a Participant PHI in a Designated Record Set to the extent required by HIPAA when the Participant requests access to this information. The Plan will disclose a Participant's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation. The Plan may elect not to treat the person as the Participant's personal representative if it has a reasonable belief that the Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Participant's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Participant.
2. **Disclosures to the Secretary of the U.S. Department of Health and Human Services:** The Plan is required to disclose the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Participant's Rights

The Participant has the following rights regarding PHI about him/her:

1. **Request Restrictions:** The Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Participant may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. **Right to Receive Confidential Communication:** The Participant has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and include how the Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. **Right to Receive Notice of Privacy Practices:** The Participant is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. **Accounting of Disclosures:** The Participant has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Participant is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Participant of the basis of the disclosure, and certain other information. If the Participant wishes to make a request, please contact the Privacy Officer.
5. **Access:** The Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Participant requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Participant wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Participant and the recipient must be clearly identified. The Plan must respond to the Participant's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Participant's request. If the Plan denies the request, the Participant may be entitled to a review of that denial.
6. **Amendment:** The Participant has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Participant's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. **Other uses and disclosures not described in this section** can only be made with authorization from the Participant. The Participant may revoke this authorization at any time.

Questions or Complaints

If the Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan using the following information. The Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Participant with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Privacy Officer Contact Information:

Risk Management Department
Montgomery County
501 North Thompson, Suite 202
Conroe, Texas 77301
Phone: 1-936-760-6935
Website/Email: employeebenefits@mctx.org

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI)**, as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents**, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
 - i. Privacy Officer.
 - ii. Risk Management Department employees.
 - iii. Information Technology Department.
 - iv. County Legal Department.
 - b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be

individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.